OVERSIGHT HEARINGS ON THE ADMINISTRATION'S HEALTH CARE PROPOSAL

HEARINGS

BEFORE THE

SUBCOMMITTEE ON LABOR-MANAGEMENT RELATIONS

OF THE

COMMITTEE ON EDUCATION AND LABOR HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

HEARINGS HELD IN WASHINGTON, DC, OCTOBER 21 AND 26, 1993

Serial No. 103–87

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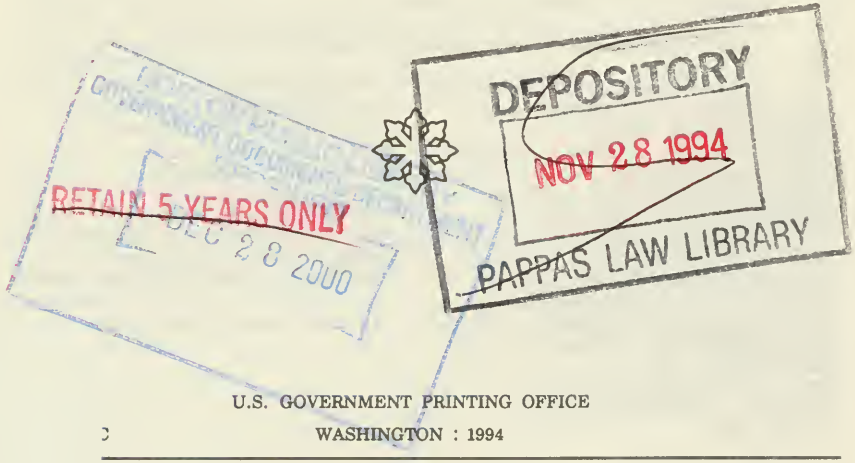

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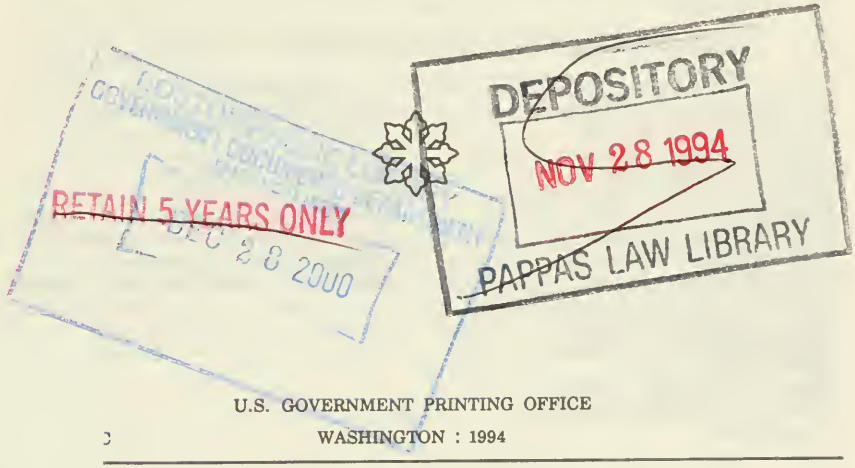

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OVERSIGHT HEARING ON THE ADMINISTRATION'S HEALTH CARE PROPOSAL

THURSDAY, OCTOBER 21, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON LABOR-MANAGEMENT RELATIONS,
COMMITTEE ON EDUCATION AND LABOR,
Washington, DC.

The subcommittee met, pursuant to call, at 10:10 a.m., Room 2261, Rayburn House Office Building, Hon. Pat Williams, Chairman, presiding.

Members present: Representatives Williams, Martinez, Payne, Unsoeld, Klink, Green, Roukema, Gunderson, Armey, Hoekstra, Goodling, Ballenger and McKeon.

Staff present: Phyllis Borzi, counsel for employee benefits; Jon Weintraub, staff director; Gail Brown-Hubb, staff assistant; Russ Mueller, actuary/professional staff member; and Patrick Beers, staff assistant.

Chairman WILLIAMS. Good morning. I call this hearing of the Subcommittee on Labor-Management Relations to order.

This morning the subcommittee will focus on the economic effect of escalating health care costs on individuals and families and businesses and the benefits that will likely flow from reforming this current health care system or non-system.

When President Clinton spoke to the American people a few weeks ago outlining the goals of his health care reform plan, he spoke first about the need for security and we all remember him holding up that health security cards. That card is the symbol of security, security of access to all, to a nationally defined comprehensive package of benefits.

The President spoke of fully portable coverage that is always there, limited not by ability to pay, not by whether or not you are sick or by the fine print in an insurance policy nor by a financial decision of an employer to provide insurance or not provide it. These health benefits that the President envisions could never be taken away.

All across this country that promise of security has struck a very responsive chord. More and more Americans understand how easy it is to lose their coverage either because the cost has been prohibitive for employers, individuals or families, or because coverage has been canceled or limited because an individual became ill or because an individual has changed jobs.

People understand how easy it is to lose that coverage and security means a great deal to them. Many businesses, particularly small ones, face similar uncertainties about their ability to obtain

insurance coverage or continue the insurance coverage that they now provide their employees. These insecurities are symptoms of the enormous toll that runaway health costs have taken on our people and on our economy.

Our witnesses today will tell their stories. Our first witness is the Chair of the Council of Economic Advisers, Dr. Laura Tyson. She will, I think, discuss problems with the current system and the economic benefits that can be gained by reform. Then we will hear from four individuals who will give us their accounts of the difficulties that they have experienced. Finally we will hear about small business concerns with rising costs.

We welcome all our witnesses here today, particularly those of you who have traveled some distance to be with us.

Mrs. Roukema?

Mrs. ROUKEMA. I would ask that my full statement be included in the record and I will try to abbreviate my opening comments and observations, first welcoming Dr. Tyson and the other members of the panel that are going to be testifying before us today.

Mr. Chairman, you have heard me say—and I certainly want Dr. Tyson to hear this comment before she addresses herself to the economic benefits of the Clinton health reform proposals—I am concerned about economic benefits, and of course, I along with most Americans want to eliminate any waste, fraud and abuse that we may have in the system. I think it is the waste that is bred of overlapping jurisdiction and lack of cohesive and coherent administrative programs.

I don't know how much fraud there is in the system, but we can all join hands in addressing those questions. My concern has been that too much of the debate has been focused on what I call the cost benefit analysis syndrome. There is more attention to health care being applied to cost benefit analysis in my opinion than as to how we preserve the quality of the health care that has always been the hallmark of the American health care system.

I want to first do that and do anticipate that we are going to have increased access along with protecting the quality of care certainly for constituents like mine. I think, however, when we go beyond that, there are legitimate questions that I would like to hear the administration address in rather specific terms and certainly from you as a representative of the administration.

I know that there has been a high profile debate as to whether or not the cost estimates can be credible or not. I understand from news reports—although I have no firsthand accounts—but news reports have indicated that there is considerable debate within the administration as to the cost estimates and the anticipated savings in the program.

Now, some may say that is not the purpose of our hearing today on economic benefits, but I would say it is at the heart of the question, because unless you know what the cost estimates are, the anticipated savings are without credibility. The magnitude of those savings are stunning, unless you know they have some credibility, there is little way that we can understand the economic impact on business and the other tangential benefits that we expect to find to our society as a whole and to the business climate.

For example, we can't talk realistically about how much this is going to increase job opportunities or cut costs to business unless we have credible cost estimates.

Secondly, certainly there are questions about eliminating those tax preferences and the whole tax question as it applies to the proposal, and I know that the President's proposal has been modified now to eliminate the tax preferences over a phase-in of 10 years. As I understand it, however, there are others, particularly supporters of the bipartisan Cooper proposal as well as some within my own party ranks that are purists on the subject of managed competition who want to eliminate those tax preferences.

I would suggest that that might not be the best thing for business, but more than that it is certainly not the best thing for the vast majority of the American people who thus far have been benefiting from good health programs from good companies where their insurance, the value of their insurance programs, are not taxed as income and their companies have received a tax preference. That all has an implication for the program as you are going to address it today and its economic benefits.

I will be directing some of my questions to you based on the accounts in this morning's paper regarding the ambiguity out there as a result of the NAM having raised some serious questions as to the benefits to the business community.

With that, we welcome you here today and we don't want to prejudice the discussion but we do want to address the issues in a forthright manner.

Thank you very much.

Chairman WILLIAMS. Thank you.

Mrs. ROUKEMA. That is a summary of my statement.

Thank you, Mr. Chairman.

[The prepared statement of Mrs. Roukema follows:]

STATEMENT OF HON. MARGE ROUKEMA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Good morning. I would first commend my Chairman, Mr. Williams, for convening this hearing this morning. As the Ranking Republican, I associate myself with the Chairman's efforts to have our subcommittee take a proactive role in this debate.

The Labor-Management Subcommittee's jurisdiction over the Labor Department, ERISA, self-insured plans or proposed "corporate alliances," and employer-mandated benefits makes clear that our work is cut out for us, and our role will be direct and significant in this health care reform debate.

I appreciate Ms. Tyson's appearance before us today, on behalf of the administration, and I look forward to hearing from each of our witnesses this morning. While we may not agree on the merits of every proposal, I know that we stand ready to work together to reach a bipartisan solution to our health care crisis.

I must also echo the sentiments heard from many of my colleagues, however, in expressing my dismay that we still have not seen a detailed, and substantive proposal from the administration. The administration would completely reshape entire Cabinet Departments and Federal bureaucracies, change the face of labor-management relations across our economy, and radically restructure the delivery of health care to hundreds of millions of Americans—and we still don't have the papers in hand! Perhaps Ms. Tyson will lend some insight into where the process is this morning.

Perhaps one single statement in the President's speech last month captured the rationale for health care reform: "Millions of Americans are just a pink slip away from losing their health insurance, and one serious illness away from losing all their savings."

Despite the fact that we enjoy the finest, most advanced system of medical care in the world, Americans live with the fear that no matter how hard they work or

how diligently they save, one catastrophic illness in the family will bring financial ruin. Furthermore, in these uncertain economic times, the loss of one's job brings not only extended unemployment but also the loss of health insurance.

However, while the President's speech was well articulated in laying before us the complexity of the health care problems, it provided only a blueprint for reform. As I indicated, we still await specific proposals, and it is clear that there remain significant problems and differences which must be reconciled.

Having served on the Republican Leader's Health Care Task Force and as Ranking Republican on the Labor-Management Subcommittee, I have had the opportunity to meet with the President and the First Lady, Labor Secretary Reich, Health Secretary Shalala, Mr. Magaziner, and other members of the task force staff over the last nine months. Based on these discussions, my own observations and concerns with the President's proposal are:

• **Credible cost-estimates, and anticipated savings.** The cost estimates and methods of paying lack credibility and have not been substantiated. How the universal coverage will be paid for is highly debatable—if I am not mistaken, even among the President's own advisors. We have been told that under the President's plan there will be more benefits and universal coverage, less cost, and deficit reduction to boot. That sounds like a free lunch, but am I wrong to assume that there will be some who will get less and pay more under the President's plan?

• **Eliminating tax preferences.** Related to my concerns with the impact of this proposal on business, I am deeply troubled that we would even attempt to tamper with the traditional tax preferences accorded health care benefits. Under the President's plan, my constituents—many under employers who have long been "corporate good citizens" in providing excellent health benefits, and many employees, who have received extensive, high-quality coverage—will now see their tax deductions eliminated, or have their health care benefits taxed as income.

Once they understand this, I can tell you confidently that the American people will not sit still or accept such a proposition. **Less coverage and higher costs are not what the American people had in mind when they voted for "change" and health care reform.**

• **Economic impact on business.** Cost estimates and cost savings of the President's proposal have yet to be documented by any objective source. This is critical, as the questions surrounding the costs to small business and the potential job losses are highly charged, and will be at the center of the cost estimates debate.

• **Complexity.** The structure of the President's plan is convoluted and complex. It creates a National Health Board and regional "health alliances" which set insurance premiums and manage costs—the actual complexity, responsibility, and operations of which have only begun to be discussed. The devil will certainly be in the details, and these are details we have yet to see.

• **Disincentives for Corporate Alliances.** Under the President's plan, so-called corporate alliances could be formed for companies and multiemployer plans covering 5,000 or more full-time employees. Among other things, these corporate alliances would have to (1) pay up to a 1 percent payroll tax to fund coverage for the unemployed; (2) establish trust funds and reserves; (3) contribute to a newly established Federal guaranty fund like the PBGC (which is currently running a $2.7 billion deficit); and (4) meet cost controls and other reporting requirements. Also, neither the companies nor their employees would be eligible for the premium cap, early retiree, and other individual subsidies which are supposedly offered under regional alliances.

With these kinds of disincentives, my question is: why do you think any of the 900+ companies eligible to form corporate alliances would do so? Aren't we really suggesting that the incentives are all toward abandoning self-insured plans and enrolling in the government-run pools?

• **Less Technology?** CBO issued a study this month questioning the efficacy of premium controls, saying that they would have "undesirable consequences" such as "technological progress in health care would probably occur more slowly ... limits on premium increases would affect both the quantity and quality of health insurance coverage available to consumers and their future access to new medical technologies." **Why would you want to limit Americans access to new technology?**

• **Draconian cuts in Medicare.** Of course, as I have observed before, the magnitude of the cuts in the growth of the Medicare program called for in the President's proposal are simply unsupportable. It has yet to be explained to me

how we can so radically slash the Medicare budget, and not ration care, and reduce the quality of medical care, to our Nation's elderly.

I would also be interested in hearing your comments on what changes we can expect in the behavior of businesses in providing *high quality* coverage—not merely a government-imposed minimum or standard. It seems clear to me that these changes in the tax preferences represent a clear "out" for businesses, and an excuse to scale back on the coverage they have traditionally provided.

• **Premium Caps and Price Controls.** Under the President's plan, it is my understanding that States would be responsible to see that the average premiums charged under regional alliances be held to the annual limit set by the National Health Board. Under the plan, would States be given the flexibility to meet their responsibilities by establishing hospital and doctor rates to achieve the desired goals?

In the alternative, to keep premiums from exceeding the annual limit, could States eliminate insurers or corporate alliances, fix hospital budgets, or institute other means of reducing the utilization of medical services?

These are some of the most immediate and pressing issues I see as we begin the health care reform debate, and I look forward to hearing the answers to these questions—if they can be provided and documented.

Finally, I offer one caveat: every member involved in this debate must understand that health care reform cannot be addressed as a simple "cost benefit analysis" or accountant's balance sheet. What Americans meant when calling for reform was relief from the "pink slip" anxiety and fear of financial ruin when serious illness strikes a family. Reform is maintaining the high quality of care and choice they have come to enjoy, and extending those benefits to all Americans.

Nevertheless, it is telling that we have begun to move in a bipartisan manner toward sweeping reform of our health care system. The work of creating a future of health security and economic security for our generation and the next is a challenge we must face together, in the spirit of goodwill. I look forward to today's hearing, and yield back the balance of my time.

Chairman WILLIAMS. Do any other members wish to make an opening statement before we hear from Dr. Tyson?

Mr. GUNDERSON. She used up all our time.

Chairman WILLIAMS. Dr. Tyson, we are pleased to have you with us and we eager to hear your testimony.

STATEMENT OF LAURA D'ANDREA TYSON, CHAIR, COUNCIL OF ECONOMIC ADVISERS

Ms. TYSON. Thank you very much.

It is an honor and a pleasure to be here to discuss health care reform with you.

My comments really fall into two parts. First, I will specify five reasons why I believe we need to reform the current system and then I will briefly talk about what I believe to be the major economic effects of the kind of reform we are proposing.

You already alluded, Mr. Chairman, to some of the reasons why we definitely need to do something to the current system. The first problem with our system is that it does not provide security to individuals. When people get sick, the cost of their coverage can increase dramatically. They can be dropped from coverage all together. This is a result of risk selection processes on the part of insurers, who are responding to private incentives good for insurers, but bad for the insurance system.

Insurance is supposed to provide coverage for risk. We have an incentive and a practice which is profitable for any one insurer, but is socially wasteful.

The second problem with our current system is that it interferes with the employment decisions of individuals. Almost 40 percent of insurers exclude preexisting conditions from their coverage of newly insured people. This locks individuals into their current em-

ployment because of being locked into their current insurance policies.

Up to 30 percent of employees in surveys indicate that they feel locked into their current jobs. Other feel they cannot form small businesses because the cost of getting insurance as a self-employed individual is prohibitively high. People are locked into welfare because they will lose their medicaid coverage if they take a job.

One of the hallmarks of a modern industrial economy in a competitive world environment is change and flexibility and our current insurance system does not encourage change and flexibility; it encourages job lock, welfare lock and inflexibility.

The third problem is simply the number of people who do not have access to affordable insurance. The number is large compared to other advanced industrial countries and it is expanding. Over 37 million people don't have health insurance. Nearly 50 percent have lack of insurance for more than a year.

This is not a predicament unique to the unemployed contrary to what many Americans believe. Three-quarters of all uninsured people are in working families and over one-third of the uninsured are in families with at least one full-time worker. So we live in a system where even if you work full time, you may not be able to provide insurance to yourself and your family.

It is also a myth that the insured do not have to worry about the uninsured, because under our current system, the insured pick up the bill for the uninsured. The uninsured pay only 20 percent of health costs they incur. The privately-insured pay 130 percent of the costs they incur.

According to recent estimates, there is about $25 billion in uncompensated care being paid for by the insured in 1994, providing health insurance for all Americans with lower premiums for those currently insured by over 10 percent.

The fourth problem with our health care system is the health care costs are high and rising. No other country spends more than 10 percent of its GDP on health care. The United States spends 14 percent. American consumers spends more on health care than on fuel oil, electricity, natural gas, oil and gasoline, local transportation, furniture and other household equipment combined.

We spend a lot of money on our health care. Spending all that money, we still have a system in which 37 million people are not insured. There have been some signs that health care inflation is moderating somewhat, but I want to emphasize there is no solution in sight.

During the last quarter, health care inflation was still three times as rapid as overall inflation. During the last year, health care inflation was at a rate of 5.7 percent compared to overall CPI inflation of 2.7 percent.

Another way to look at the health care spending burden is look at it on a per-working-American basis. Health care spending per working American in 1994 will be over $7,000. American workers on average pay $1,864 directly for their health care. Their employers will pay an additional $3,409 and Federal, State and local taxes for health care which will total per working American $2,149.

Now empirical research suggests that in general businesses respond to higher health care costs by adjusting over time the wages

that they pay to their employees. They also try to take the tax burden for government health care spending and to some extent share that with workers in the form of slower growth of compensation.

That is why if you do the following experiment in your head, if employer contributions to health insurance had remained constant at their 1975 share of compensation through 1992, real wages per worker might have been over $1,000 higher in 2002. Workers have paid for the health care system we have in place over time in part by slower rates of growth in their wage compensation.

The fifth problem with our health care system is that there is a substantial amount of excess supply, misallocation of resources and inefficiencies. This is not primarily because of greed on the part of doctors or greed on the part of hospitals. This is a problem of poor competition, lack of effective competition, and poor incentives.

Certainly there is some fraud and abuse; a recent study suggested it might be as much as $80 billion a year, but the real problem is the incentive system and the lack of competition.

We have a tremendous administrative burden in our health care system as currently organized. Over 5 percent of our total health care spending, about $45 billion, covers administrative expenses and paperwork.

We have studies which indicate that perhaps as many as a third of common medical procedures may be inappropriate or unnecessary. We have a phenomenon which is surprising to economists, certainly, that in part of the country where there are hospital beds and excess supply or equipment excess supply, prices rise rather than fall.

We normally think prices fall in conditions of excess supply. We do have substantial evidence from a variety of State experiences and company experiences that HMO's as a way of providing care may cut the cost of medical care by up to 10 to 20 percent without reducing the quality of care.

These diverse indicators paint a picture of inefficiency, excess supply and misallocation so that a very important reason for economic reform of this system is to improve its efficiency. We have one-seventh of the economy where there is substantial evidence of excess supply of resources. If we can improve the functioning of that part of the economy the entire economy will benefit.

Those are my five reasons for why we need economic reform of the health system.

Let me talk about the major effects. First, many employers who currently offer health insurance will see their costs fall immediately. Under the health security plan that we propose, every individual will receive health insurance. This will eliminate uncompensated care in the current system. That will lower cost of businesses currently providing care, making resources available for use in a variety of ways.

Businesses that see their costs decline can increase wages, can hire more people, can invest more, can offer price reductions on their products. Those who are currently offering care or health insurance also benefit from eliminating corporate free riders.

Companies currently provide health benefits for their employees and for their spouses who are not covered by their own employers.

A second point about our health care plan is that it will gradually reduce aggregate business spending on health insurance. Initially businesses who are currently providing, many of them will see a reduction in their costs. Over time as the rate of growth of health care costs slow down, the business sector in aggregate will see a reduced spending relative to what would have been the case otherwise.

In fact, by the end of the decade, our estimates suggest that aggregate business spending on services provided in our plan will fall by $10 billion. Small businesses, contrary to much speculation, will be particularly benefited from the health security plan in both the short run and the long run.

Currently small businesses that provide insurance face administrative costs of up to 40 percent while large businesses face costs of only 5 percent. Under reform, we think the administrative costs for small firms will fall by up to 25 percent.

Currently small firms pay up to 35 percent more for the same insurance as a large firm and the cost of the small firm sector for providing insurance is growing twice as fast as the cost is growing for the large firm sector. So small firms who are trying to provide insurance and most of them—for example, 64 percent of small business owners say they would like to or they would like to improve what they are providing—it is these small firms that are taking the biggest hit.

Their costs are higher. Their costs are rising more rapidly. They are being priced out of the insurance market.

Furthermore, in our plan we offer substantial discounts to small firms. We estimate that for many small firms, say a small firm hiring a minimum wage worker, there would be no more than an increase of 15 to 35 cents an hour to provide comprehensive coverage for this kind of worker. It should not be surprising that when small firms look at what we are proposing, many of them who initially felt concerned about the plan have come around to support the plan because if you take a firm that wants to provide insurance or is currently providing insurance and you offer them the ability to provide with a substantial discount, they find it very attractive.

Another economic effect of the health security plan will be to encourage employment in the health care sector in the short run and a more efficient health care sector in the long run. With the increase in the number of insured Americans, there will be a significant expansion initially in the employment of health care providers. It will be a significant enough expansion to more than offset any decrease in the employment of health administrators and insurance workers.

We have done some estimation of this, and looking at the increase in the number of health care providers and the decrease in the number of health administrators and insurance workers, we come up with an estimated net increase of new jobs in the health sector of about 400,000 jobs.

As the cost savings of the health care system begin to cause costs to grow more slowly, there won't be an absolute decline in health care sector employment. There will be a slowdown in its rate of increase.

Another important effect of our plan will be to reduce job lock and welfare lock enabling workers to be more efficiently employed, allowing them to make more productive choices for themselves. This should help small firms in their ability to attract workers from large firms. So there is the enhancement of mobility of workers.

So there is the possibility that some workers may decide to leave the labor force altogether. There may be an increase in retirement as a result of our health care reform.

There has been considerable speculation about whether or not the reform will cause a change in aggregate employment levels. There is a concern that many have voiced that because the system is based on an employer mandate it will cause a reduction in aggregate employment. The question is, is that true?

I want to indicate, this is not a world—we are not starting in a world in which no employer is currently providing insurance and all of a sudden all employers will be required to do so. Most workers are already covered by their firms.

We are also not starting in a world in which all employers will see their costs of employment increase as a result of our mandate. We estimate that employer spending for the already insured will decline as a result of our reform so that many firms will see their costs fall in the short run and in the long run. Other firms may see an initial increase, but then will see a slowing down of costs.

We are also not starting in a world of health care cuts. It is a mistake to think of this as a world in which we are going to require a reduction in health care sector employment. We believe that what the effect will be initially, an increase in health care sector employment by about 400,000 jobs and then a slowdown in the rate of growth employment over time.

So in the world we are starting from, what are the likely effects on overall employment? We have looked at this question with considerable care, as have others. The emerging conclusion in the economics community is that it is very hard to predict the employment effects with any degree of precision, but at the aggregate level. They are likely to be small.

Let me try to explain why it is hard to make the prediction with precision but why they are predicted to be small.

It is hard to make the decision because the appropriate model for predicting the employment effects would have to make distinctions between firms that currently provide and will see their costs come down and firms that currently do not provide and will see their costs go up.

You have to have a model that allows you to look at that offset. In addition, you would have to have a model which allows you to say, how will the firms who see their costs go down, what would they do with that benefit?

Will they employ more people? Will they raise the wages of the workers they currently employ? Will they invest more? Will they offer price reductions on their products?

We don't know for sure how the firms that benefit will respond. We don't know for sure exactly how firms who see a cost increase will respond. They might respond by slowing down the wage

growth of their employees and not by reducing the number of their employees.

We don't have models that can make these kinds of distinctions.

What we do know is that if you take existing models, which are not well designed to do this, you can generate small net positive or small net negative effects on employment depending on the assumptions you are willing to make about how these different categories of firms respond.

It demonstrates the old adage that what you get out of a model is what you put into the model. What you build in in your assumptions pretty much determines what you get out at the other side. So it is not a surprise that several private sector economists have concluded as we at the CEA have concluded that the net effect of our health care plan on the aggregate employment level is likely to be small.

Our internal estimates suggest a range of plus or minus one-half of one percent of the aggregate employment level. The basic reason is because there are some factors that are working to increase employment, bringing down business costs, making firms better off, there are some factors working to decrease employment.

The net respect is likely to be small. We know for sure that over time the beneficial effects on the business community increase because over time aggregate business spending in fact falls below baseline.

On balance, then, I am certain that the health security plan we are proposing is good for the American economy, it diminishes job lock, it diminishes welfare lock, it allows more people to become self-employed, it gets our health care costs under control while guaranteeing health security to all Americans.

It will, by improving incentives, reduce excess resources and misallocation of resources in the health care sector and that will make us a more efficient economy.

I am happy to answer any questions that you may have.

[The prepared statement of Ms. Tyson follows:]

Testimony of Laura D'Andrea Tyson
Chair, Council of Economic Advisers
House Committee on Education and Labor
Subcommittee on Labor-Management Relations
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THE ECONOMIC EFFECTS OF HEALTH CARE REFORM

Thank you, Mr. Chairman, for the opportunity to come before your Committee to discuss the economic effects of health care reform.

The United States is facing a health care crisis. The rapidly rising cost of health care hurts businesses, depresses wages, and contributes to fiscal imbalance. The average working American will be charged, directly and indirectly, over $7,000 for health care in 1994. The lack of health security makes many individuals afraid to leave their current jobs, discourages others from working for small businesses or becoming self-employed, and keeps people on welfare instead of working.

Reforming health care is a difficult challenge, but one that we must face. Let me first outline the problems that force us to take action, and then I will move on to the economic effects of the Health Security plan.

Why Reform Health Care?

There are five reasons why urgent health care action is needed.

The first problem is that our health care system does not provide security to individuals. When people get sick, the cost of their insurance can increase dramatically, or they can be dropped from coverage completely. This situation is a result of risk selection practices on the part of insurers. Insurers spend large amounts of money trying to select good health risks, and avoid bad risks. This practice is profitable for any one insurer but is socially wasteful. After all, someone must cover the costs incurred by people who get sick. The result is that many people cannot get coverage, and many more fear for their ability to get coverage in the future.

The second problem with our health insurance system is that it interferes with the employment decisions of individuals. Almost 40 percent of insurers exclude pre-existing conditions from their coverage of newly insured people, thus locking many people into their current insurance policies and jobs. Up to 30 percent of employees feel "locked" into their jobs. Others do not form small businesses or become self-employed because of the difficulty of

obtaining insurance. Finally, many people remain on welfare because they will lose their Medicaid coverage if they take a job. If we are to adapt to changing domestic and international economic circumstances, we must not penalize people every time they change or lose a job.

The third problem with our health care system is that the number of people who do not have access to affordable insurance is large and expanding. Over 37 million people do not have health insurance. And this is not a predicament unique to the unemployed. Three-quarters of all uninsured people are in working families, and over one-third of the uninsured are in families with at least one full-time year-round worker. We have a system in which millions of people, many of them in working families, cannot afford the rising costs of health care coverage, and they face the risk of being financially crippled by events beyond their control.

It is a myth that insured people do not need to worry about the uninsured. Under our current system, when the uninsured face catastrophic costs, the insured pick up the bill. Currently, the uninsured pay only 20 percent of the health care costs they incur, while the privately insured pay 130 percent of their actual health care costs. According to recent estimates, there will be about $25 billion of "uncompensated care" paid for by the insured in 1994. Providing health insurance for all Americans could therefore lower premiums for the currently insured by over 10 percent.

The fourth problem with the health care system is that health care costs are high and rising. No other country in the world spends more than 10 percent of its GDP on health care. The United States spends 14 percent. American consumers spend more on health care than on fuel oil, electricity, natural gas, other household operations, oil and gasoline, local transportation, furniture, and other household equipment combined. Even though health care inflation has moderated recently, during the last quarter it was still three times as rapid as overall consumer price inflation.

Health care spending per working American will be over $7,000 in 1994. American workers will, on average, pay $1,864 directly for health care in 1994. Their employers will pay an additional $3,409. And Federal, State, and local taxes for health care will total $2,149.

Empirical research suggests that businesses generally respond to higher health care costs by lowering the wages they pay to their employees. Similarly, the taxes required to pay for government health spending are borne to some extent by workers in the form of lower wages. Thus, if employer contributions to health insurance had remained constant at their 1975 share of compensation through 1992, and if employers had passed these savings on to workers, real wages per worker would have been over $1,000 higher in 1992.

The fifth problem with our health care system is that it is riddled with waste, excess supply, and inefficiencies. Despite our massive commitment of resources to health care spending, the United States ranks 19th out of 26 countries in infant mortality and 18th in life expectancy. We lose an estimated $80 billion a year to fraud and abuse. Over 5 percent of our total health care spending--conservatively $45 billion in 1992--covers administrative expenses and paperwork.

As many as one-third of common medical procedures may be unnecessary and inappropriate. Hospital prices continue to rise even though hospital beds are in excess supply in many parts of the country. HMO experience indicates that the cost of medical care can be cut by as much as 10-20 percent without reducing the quality of care.

These diverse indicators paint a compelling picture of the inefficiency and waste in our current health care system. Perhaps the most important economic reason for reform is to improve the efficiency of this system. This in turn will make resources available to cover the uninsured and to address our other pressing economic and social needs.

The Economic Effects of Reform

The Health Security plan addresses these fundamental problems with the current system. It will lower costs, provide security, increase job opportunities and increase the efficiency of the economy. Many businesses will see their costs fall, and many others will have access to coverage previously denied them. Slower cost growth will allow workers to enjoy faster growth in their real wages, and reduced job lock will increase workers' ability to find better jobs. Let me describe what I believe to be the important economic effects of health care reform.

First, many employers who currently offer health insurance will see their costs fall immediately. Under the Health Security plan, every individual will receive health insurance. Eliminating uncompensated care in the current system will lower costs to businesses that provide care, thereby making resources available for increased wages or additional hiring. Eliminating corporate "free riders" will also reduce spending by companies that currently provide health benefits for their employees and for their spouses who are not covered by their own employers.

Second, the Health Security plan gradually lowers aggregate business spending on health insurance. Although the business sector as a whole will initially pay more for health insurance, the reduction in health care cost growth lowers the growth of premiums over time. In fact, by the end of this decade, preliminary estimates indicate that aggregate business spending on services covered by the Health Security plan will fall by $10 billion.

Businesses can do many things with the resulting cost savings. They can. hire more workers; raise wages or provide better benefits for existing workers; invest in more plant, equipment, education and training, and research and development; increase dividends to shareholders; or lower prices, thereby leaving consumers with more income to spend on other goods. Each of these outcomes will have a stimulative effect on the economy and will increase employment. Economic research has not reached clear conclusions about how to apportion the savings among these effects. Almost all models suggest that wage increases are a likely response, but they differ about whether all of the savings will flow into wage increases. Nevertheless, the effects of lower health care spending are clearly beneficial for the economy.

Small businesses will particularly benefit from the Health Security plan. Currently small businesses that provide insurance face administrative costs of up to 40 percent, while large

businesses face costs of only 5 percent. Under reform, administrative costs for small firms will fall by up to 25 percent. Additionally, many of those currently insuring small firms will receive discounts on their premiums.

Although small businesses that do not currently provide insurance will pay more, they are likely to receive discounts to make health care affordable. There is a common myth that small businesses cannot afford to pay anything for health insurance. In fact, many small businesses report they would like to provide health insurance for their employees if it were more affordable. According to a recent study for the NFIB performed by Charles Hall of Temple University, 64 percent of small business owners would like to provide some or better insurance for their workers. When asked why they do not offer insurance, the most common response (65 percent) was that premiums are too high. Ninety-two percent of small business owners agree that the cost of health insurance is a serious business problem. Under the Health Security plan, with affordable health insurance and discounts for small businesses, this will no longer be the case.

Third, the Health Security plan will result in greater employment in the health care sector in the short run and a more efficient health sector in the long run. With the increase in the number of insured Americans and the decrease in the administrative burden of health insurance, there will be a significant expansion of employment of health care providers and a decrease in employment of health administrators and insurance workers. By 1996, as many as 400,000 net new jobs will be created in the health sector. As the cost savings of the plan begin to accrue, employment in the health sector will grow more slowly, although there will be no absolute decline in the number of employees.

Over time, the health sector will become more productive. This benefits all of us. We will be able to have the same or better health care as well as more investment, research and development, or just plain goods and services.

Fourth, the efficiency of the economy will also be increased by reducing job lock and welfare lock. By providing health care security, the reform will give workers the freedom to move to jobs where they might be more productive without having to worry about losing their health insurance. Small firms should particularly benefit from this, since they often have the hardest time attracting highly skilled workers. In addition, firms should be more willing to hire workers with pre-existing conditions because the new system does not penalize individuals with a prior illness. This allows for better, more efficient matches between employers and employees and increases the efficiency of the economy.

Some workers may decide to leave the labor force completely when there is continuous health coverage. Evidence suggests that about 350-600,000 people will decide to retire early under health care reform. This increase in voluntary retirement may increase employment opportunities for younger workers.

As you know, some have claimed that the Health Security plan will cause substantial damage to the economy. There is no denying that some firms and individuals will pay more than

they did prior to reform. In particular, the Health Security plan will increase costs for some young, single individuals as well as for firms that did not previously offer health insurance. The vast majority of Americans, however, will benefit from the reduction in health insurance costs, the portability of coverage, the lower administrative costs, the reduction of job lock, the lower costs for small businesses and the self-employed, and the reduction in welfare lock. In addition, as already noted, many employers, both large and small, currently providing insurance will enjoy lower costs immediately and the business sector as a whole will enjoy lower costs within three years of the plan's full implementation.

Summary Conclusions on the Likely Economic Effects of Health Care Reform

Neither the models nor the data are available to yield a precise estimate of the employment effects of health care reform. In many other areas of economics, there are models that have been tried and tested for decades, and economists generally place a good deal of faith in the outcomes they predict. Standard macroeconomic models, for example, can make reasonably precise predictions about how a tax increase or a spending cut will affect aggregate output or employment.

But there are no existing models that allow us to predict the employment effects of health care reform with the same degree of precision. This is because the appropriate model for such an exercise would have to make distinctions both between firms that currently provide insurance and those that do not and among the many ways that firms in either group might respond to a change in their health care costs. Such a model would also have to predict how individuals might respond to new incentives in the plan, particularly those affecting small business creation, job mobility, welfare lock, and retirement.

In the absence of an appropriately specified model, one can generate either small net positive or small net negative effects on employment with existing models depending on the assumptions one is willing to make--demonstrating the old adage that you get out what you put in. Not surprisingly, several private-sector economists have concluded, as we at the CEA have concluded, that the net effect of our health care plan on the aggregate employment level is likely to be small--our internal estimates suggest a range of plus or minus one-half of 1 percent of the aggregate employment level. This is because although there are some factors in the plan that will tend to decrease employment, there are others that will tend both to increase employment and to change its composition. These offsetting factors are likely to cancel each other out, although over time as business spending falls below baseline, the factors encouraging an increase in employment are likely to strengthen.

On balance, I am certain that the Health Security plan is good for American business and the American people. It diminishes job lock and welfare lock and allows more people to become self-employed. It gets health care costs under control. It guarantees security to all Americans.

And it reduces waste and inefficiency in one-seventh of our economy. Reorganizing our health care system to use our scarce resources more efficiently will help us realize our goal of realizing higher living standards for ourselves and our children.

I will be delighted to answer any questions that you may have at this time.

Chairman WILLIAMS. Would you speak to the potential effect that the administration's plan will have on lower wage workers?

Ms. TYSON. Well, I think here you have to look at what the plan is actually doing. First of all, it is important to emphasize that we have to again think about there are low-wage workers who are already covered. For those low-wage workers, as for high-wage workers who are already covered, we estimate that for most folks the immediate effect will bring the cost of coverage down. We have to first distinguish between whether the low-wage worker is insured or not.

For low-wage workers that are not insured, we have been very sensitive to this question from the beginning which is why we have built into our plan a substantial generous set of subsidies primarily targeted at low wage small firms, the reason being that if you look to see where are the low-wage workers who are not currently covered, that is where they predominantly are, in low-wage, small firms.

So we have a subsidy scheme which as I said turns out to amount to no more than a 15 to 35 cent increase in the wage of these workers and for that amount of money what the firm will be able to provide is a comprehensive benefits package. That increase in the hourly rate of pay, of compensation, would leave the minimum wage, for example, still substantially below where it was in the 1980s.

So we are aware of this problem and we have designed discounts to take account of the problem.

Chairman WILLIAMS. Could you speak to the credibility of the financing in the administration's plan? The Congress and I think the American people understandably have become leery of cost projections because we find, as does the private sector, that projections in the past missed the mark sometimes by a significant amount, and I find back in Montana with my own constituents, as I am sure my colleagues do, many questions about whether or not the financing, as nearly as we can define what the financing is, whether or not the financing is credible.

Ms. TYSON. I can make several observations.

First is to get at the observation of where we think we can end up without reform and where we think we can end up with reform and whether that difference in ending point is credible or not. Without reform, the current estimates are that in the year 2000 we will spend $1.63 trillion or 18.9 percent of our GDP on health care. If we don't reform, we will be spending that much of our GDP on health care without universal coverage.

With reform, we have a plan which gets us to a year 2000 spending level of $1.49 trillion or 17.3 percent of GDP. What is the savings we think we can get by the year 2000? It is less than 10 percent of total spending in the year 2000. So you take projected spending in the year 2000 and say we think by reforming the system we can get a 10 percent reduction in costs relative to where they would have been otherwise.

This does not seem to be a big number if you look at other numbers that I have suggested, the extent of fraud and abuse, the extent of administrative excess in the system, the evidence coming in

HMOs. There seems to be substantial room for by the year 2000 a 10 percent reduction in overall spending.

A second point I want to make is that during the period of 1996 to 2000, the years in which the health care reform package would be gradually phased in, we are basically projecting health care spending to grow at CPI plus population plus 3.3 percent.

If you look at the rate of growth we are projecting, we are in the mid range of country experience over a five-year period. We are starting from a very high level of spending. In terms of where we think we would like to go, we are asking for a credible outcome. Underlying estimates—we have done a tremendous amount of work on estimates of the premiums that would have to be paid for the package of services that we have proposed.

These numbers have been judged to be sound and reasonable and the best possible estimates available by outside actuaries as well as our actuaries.

We furthermore have built into our scheme cushions. In the subsidies we will be proposing, we have a 15 percent markup of cushion. We understand that the world is uncertain and that any given year the subsidies may require more funds than we anticipate, so we built a cushion in.

We view our global budget caps as an emergency or safety clause. The health care experts we have spoken to believe that with the proper incentives, the system can generate savings to get it down by 10 percent in the year 2000 without having the global budget caps become binding. But if the system fails, we want to assure the American people that there will be a cap on what the Federal Government's liability is here and on what the private sector's liability is here.

So we have a fail-safe mechanism for an emergency brake in place.

Let me say as an aside that CEA was involved through this process of putting together these numbers in the last nine months and I believe that we have put together the best possible estimates from the best possible set of studies that are available to anyone. The real issue is how do you deal with some uncertainty which is always there.

We have no crystal ball, we don't have a world of perfect certainty. We have tried to deal with it by putting in cushions and by putting in a global budget.

Chairman WILLIAMS. Thank you?

Mrs. Roukema?

Mrs. ROUKEMA. You have given us a lot to think about here. I won't belabor the question of those cost estimates but as I stated to my four community meetings that I had last weekend—and by the way most people agreed with me—that the question being raised about the cost estimates that have been criticized on a bipartisan basis—and I won't refer to the particular Senator from the Northeast who called it fantasy, but I happen to associate myself with that comment as do most people in my district—is that they lack credibility, and I concur.

I want to concentrate on some of the specifics here because I think you have made an excellent point concerning the analysis of the problem and things that I think we could all agree that we

want to solve, namely the insurance reforms that will give us portability and eliminate the part-timing of America which employers are now using as a method of escaping the responsibility for providing health insurance; that plus the malpractice reforms which you have identified as cost savers, at the same time expanding the program to cover those who are not presently insured which could essentially be an expansion of Medicaid so that those people can be covered—that seemed to me and many in my constituency to be the essence of the problem in addition to this ethereal improving administration and cutting the waste out of the system.

Unfortunately, many of us, including the NAM and a lot on our side of the aisle, feel that the administrative proposal that you have outlined is perhaps more cumbersome and certainly does not give us the savings that one would have hoped for.

I don't have a better answer for it, but I think we have to come to a program that will genuinely give us less administrative overhead and a less convoluted system. But what would be wrong with—some people don't like the word incremental, but I do—what would be wrong with an incremental proposal that determined at this time that we could all agree on those insurance reforms, expanding Medicaid to cover the low-income workers that you have just identified, and whatever we can do in the malpractice area as the first step, and then we don't really have to argue at this point in time, we can argue later on about what the savings might be.

Then we get into lots of questions about rationing care and limiting care as we have in the State of New Jersey, when the most prominent HMO in the State said "We are going to save costs. We will send our new mothers home from the maternity ward in one 24-hour period instead of three days. That saves."

Ms. TYSON. I think I understand why people when they first hear about the plan say "Well, how can this be?" I have to say that when I first got involved in these discussions I had the same reaction.

I like to believe that we have a very efficient system, the entire economy is very efficient and it works like clockwork. What is staggering to me is to find study after study of an industry which encompasses a seventh of our economy, which indicates that this is not an efficient part of our economy, not because we don't have the incentives in place for it to be efficient. So I am struck by the fact that the CBO does a study in March 1993 looking at all the managed care arrangements around the country and concluding that we can get savings of 10 to 15 percent without a reduction in quality of care.

What I don't know about the statements of the women going home in a 24-hour period, I don't know whether that is a reduction in the quality of their care or not.

Mrs. ROUKEMA. There is no debate about that.

Ms. TYSON. What I have seen is study after study which suggests that for the same quality of outcome we could be spending 10 to 15 percent less per patient. I admit that is a surprising number, but people need to look at the evidence on this.

As far as could we just go for a medicaid solution, the problem with that as I see it is we know that what is going on in the current system is that medicare and medicaid is underpaying and

then the tax or the additional payment for those services is showing up in higher premiums for the insured. So if we just try to handle the overall problem with a quick fix in one part what will happen is we will, the insured will pay for that in ever escalating insurance premiums.

So I don't see how we can go that route without at least notifying the American public what will be the consequence of this is further escalations in the cost of private insurance to take up the coverage of the medicaid population.

I understand that Members of Congress are very interested in the notion of slowing down the rate of increase of both medicaid and medicare and if we don't go for a comprehensive reform, but say let's take uninsured and put them on the medicaid budget, we will see an escalation in the rate of growth of medicare spending.

We have thought about these kinds of limited options and were compelled by the fact that if the limited options don't solve the problem they move it to another part of the system. That is why a comprehensive reform seems to be the only sensible strategy.

Mrs. ROUKEMA. I would like to explore the question of medicaid and how that would be paid for in another forum. I appreciate your comments.

Chairman WILLIAMS. Mr. Martinez?

Mr. MARTINEZ. All we have seen is reports. We haven't seen legislative language yet.

Ms. TYSON. I believe it will be the middle of next week.

Mr. MARTINEZ. Until we do is we don't know how to get clear legislative answers to the questions we have and what we do about the things that we don't totally agree with. I don't think there is any plan that will come to the Hill that every Member of Congress will agree with. But what I do know and the people that I have talked to in my district and people outside, almost every place I go you get into a conversation about health care reform and national health care.

Almost everyone I talk to, and I guess it might be the same with everyone else, is confused, and confusion has a tendency to scare people.

One thing we know on the Hill is that when we pass out complicated legislation like day care or things like that that then it is left up to the bureaucracies to promulgate regulations by which it will be implemented. It is never with the intent that the Congress passed the legislation.

So as a result that complicated legislation tends to be convoluted by the regulations and the bureaucracy. So always in our minds that worry is there and what is going to happen.

We seem to have had a task force that took testimony and listened to everybody's concern and seemed to try to cover every contingency.

In the reports that we have heard back you talk about the things that were brought up and what you did to counteract any adverse impact, and still I have a lot of questions just from the report.

For example, you have a 10-year date in which all the plans that are there now are not only grandfathered, because if they were they would go on ad infinitum until the agreement was busted, but

in 10 years people that have agreements will then be covered by some portion of the plan, for example, the early-out retirees.

We understand that the administration will drop the retirement age to 55 to be eligible for payment of their health care from the Federal Government. But there are today in the early-out retirements, they are not 55 any more.

My son is only 42 and he took early-out retirement from the telephone company. Part of his agreement didn't cover his health care coverage, but there are a lot of people that the company in order to get them out do. They would be covered until they died under that agreement. But under this plan after 10 years, they then have to look at a different way of doing it, and that gives me some concern, why we set 10 years as a date.

The other problem that I have with it is that after 10 years those existing plans—I am thinking here primarily about small businesses where an employer has made an agreement with his employees. I laugh at the new terminology we use any time we are trying to promote or sell legislation—we use now the word "alliances." Alliances have been out there for a long time.

Small businesses who formed an association for their business formed an alliance to get insurance because as individual employers with five or six employees, they couldn't afford the premium at the rate it was.

I was part of one of those way back some 25, 30 years ago. The business that I had, we formed an association more for getting an insurance company in than for other benefits.

The first insurance company that we negotiated with, we negotiated as a group and a certain size group and we got the best kind of a plan we could get for the dollar we could afford to pay. Now it seems to me there will be alliances out there, depending on their size, they are going to negotiate with the insurers to determine what kind of a rate they will pay for what kind of a plan, and that will be inconsistent across the country depending on the size of the alliance and the insurance they are willing to get to talk to them. I find that confusing.

On the one hand, we are talking about setting caps and making sure that all the insurance coverage meets a certain level. One thing I found as a young man a long time ago, when you buy insurance you may pay a different price, but you are getting different coverage, and when you measure it all out, you only get as much coverage as you pay for.

So that the insurance companies have a way of saying we will give you this that makes it seem like a big thing to you, but taking away this over here. That is a fact of life.

So I have no confidence in insurance company cooperation. That may make insurance companies mad but that is the reality. I wonder why we are allowing the individual alliances to negotiate whether we have a perfect system of negotiating now.

The OMB negotiates for all those Federal employees that are insured—their rates are negotiated by the Office of Personnel Management and their benefit packages, consideration for. It seems a central place and the administration of Office of Personnel Management isn't that big especially with regard to insurance.

I don't think it would be that much greater a load on them since most of the insurance carriers that they have negotiated with insure Federal employees and most people can point to an individual plan, say a board of county supervisors that provides insurance for a particular group of people in the county, saying we have a better plan than anything the Federal Government provides.

But overall, I believe that the best insured people in the world are Federal employees and evidently Arlen Specter and another Senator feels the same thing because the Senate passed a resolution saying anything that we impose on the general public we will accept for ourselves.

It immediately brought a response from Federal employees, are we going to take a cut, are we going to take a step down? Pretty much the plans that are offered you can tailor whether you want an HMO or fee-for-service. You can choose those kind of plans that best suit you.

What is there? One hundred and twenty-seven different plans they can pick from?

Ms. TYSON. It is a large number.

Chairman WILLIAMS. The gentleman's time has expired.

The Chair would like to, because we have so many members here and because Dr. Tyson is on a limited timeframe here, would like to abide by the five-minute rule.

Mr. Armey?

Mr. ARMEY. Thank you, Mr. Chairman.

Dr. Tyson, let me express as gregariously as I can how much I appreciate you being here, how much I enjoy you being here. Everybody in the President's quasi-anonymous 500-person task force that I have had the privilege of visiting with has given me a special joy, bringing back to my mind that wonderful song from South Pacific, "Happy Talk."

There is nothing that puts me in a more joyful mood than visiting with those of you who represent this comprehensive government takeover designed to provide trickle-down health care to the American people.

Mr. MARTINEZ. Don't you know trickle down didn't work?

Mr. ARMEY. I have watched the world of work for some time. I try to watch it from as far away as possible. The wonderful innovations that we have seen in this modern age designed to accommodate the diversity of our workforce such as flex-time, part-time, shared time, and so forth, to accommodate the entry into the world of work of the American woman, has in fact I think provided an enormous range of opportunities for people to work out their family's work and income-generating relationships in wonderfully creative fashions.

Of course, to a great extent when you look at these innovations, it is part-time work that becomes the key. And yet as I read your plan, or the outline of your plan, a full-time job, usually defined as 40 hours a week, for some reason in the President's plan is defined as a 30-hour week. I would suggest that creates a strong disincentive against hiring part-time workers, because an employer under your plan who hires one 40-hour worker pays 80 percent of that worker's health care costs, but if he hires two part-time, 20-hour

workers, he has to pay two-thirds of the 80 percent for each worker, which totals 106 percent of the cost.

My question is, isn't this plan prejudicial against the hiring of part-time workers, families' second-wage earners in general, women and students in particular, and doesn't this just mitigate perversely against the trend of these wonderful innovations in the world of work we have seen in recent years?

Ms. TYSON. I think what I would want to emphasize is two things in response to that. One is it is correct that this plan would tend to encourage more full-time work as opposed to part-time work. There are two ways to read the evidence on why there is part-time work. There is a substantial and growing number of people who are on part-time employment involuntarily; that is what is happening is in order to avoid taking on insurance, companies are only offering part-time work, and that limits the options and availability of full-time work to Americans that want it.

So while it is true that this will overall encourage or provide incentive to go to more full-time jobs by employers, it should be emphasized that in fact many employers are currently limiting the availability of full-time work to people who want to have full-time work. That is the first thing.

The second thing is that again, what we are trying to do here is to take firms who are currently providing insurance and reduce the cost of providing insurance, whether the firm is small or large. If the firm is small and low wage, we are offering substantial discount for them to do this. So when you are thinking about the effects on availability of jobs, you have to think about the employers's incentive to hire.

Our view is that this will benefit employers currently insuring, will by the year 2000 on average create $10 billion of savings for the business community.

My view is this will help the creation of better jobs, more high paying jobs, more full-time jobs and more jobs over time.

Mr. ARMEY. There is a redistribution effect, since part-time workers are often in the smaller firms. Essentially you ease the burden of those large corporate enterprises that suffer bureaucratic malaise and enjoy a bureaucratic symbiosis with the government and shift the burden to the entrepreneurially creative small firm.

That is something I think you ought to look at since the dynamics in the economy come from the small business enterprise.

I want to make the observation that I find it fascinating that the task force can argue so convincingly that you can make accurate projections of total expenditures on health care as a percentage of GDP, which means you can project GDP, you can project early retirement costs and you can project prices, but you now tell me you cannot project with any accuracy the employment results. I find that incredible.

Thank you.

Chairman WILLIAMS. Mrs. Unsoeld?

Mrs. UNSOELD. I will throw out two questions. Is there a possible adverse consequence to this early-out program that we are engaged in for public employees, early retirement, not only raising the cost to government with higher health care costs, but also in terms of

other government social programs such as social security if they are going to be retiring at 62?

Let me give you the second question too because I have a number of employers in my district who are self-insured. One came in recently with 125 employees, pays total benefits. It is a family-owned affair, would like to be able to continue to be self-insured, but there doesn't seem to be any way with a 5,000-employee threshold.

Ms. TYSON. On the early retiree issue, I want to clarify something that I think is not well understood in the whole proposal. By going for a system with universal coverage and a system with community rating, which our proposal does do, there is in the situation that we have set up basically the option, the greater availability of an early retirement decision whether the government—however much the government takes on of the additional burden—an employee can decide to leave voluntarily and then based on their income they will have to pay a certain part of their coverage, but because of universal coverage as the guiding principle, and community rating the price of that coverage should they voluntarily leave employment will be much lower than the option available to them now.

Part of the retirement issue is really coming precisely from the design of the system and I believe universal coverage is extremely important to—it is critically important to the whole design. We want to get everybody in so we can get rid of cost shifting, so we can encourage people to use the system most effectively, through preventive care rather than waiting until disease comes or a situation is very advanced and needing very expensive care.

So the early retirement issue should be understood as part and parcel of that general system design.

I do think that there is in the plan an additional incentive encouraging early retirement because of the government's willingness to pick up the employer's share, and that is something which we believe will help in terms of the private sector, will help in the restructuring of many industries that need to go on to maintain U.S. competitiveness.

We have estimated a cost for this which we believe includes a cushion so that as with our other subsidies we are building in some room for unanticipated effects. I believe that the Treasury is certainly looking at the issue of how a change in the number of early retirees, and the numbers suggest maybe a range of 300,000 to 600,000 individuals would move into this option, how that would affect other tax revenues and other responsibilities, spending responsibilities of the government. That is being looked at.

On the self-insurance issue, the issue of what size firm to leave out of the alliance and what size firm to allow self-insured, I think here it is a tradeoff.

Economists say this is a real tradeoff issue. We want to get enough people into the alliance to get the benefits of market negotiating power. It is very compelling that with firms of 500 or fewer employees, only 30 percent of the workers right now have a choice. So that is blunting competition for those workers who only have one plan to choose from usually and it blunts the abilities of the employers to ally together to get a better rate and therefore more choices.

So that suggests going for a fairly large firm before you allow for self-insurance as an exclusion. So I think we are trying to balance some sort of competing goals here and that issue we can continue to look at, what is the right size cutoff, when can you keep firms out and they will still be big enough to get the benefits of negotiating well and giving choice to their employees, and when are they too small to have that negotiating power or the ability to give choice. That is the tradeoffs we are looking at.

Chairman WILLIAMS. Thank you.

Mr. Gunderson?

Mr. GUNDERSON. Thank you, Mr. Chairman.

I am sitting here, Dr. Tyson, listening to you and I have decided that of all the people in the administration, probably you and Mr. Panetta will have the worst job trying to deal with the numbers side of health reform. I think you have astutely developed a package that is much more lucrative than money will allow us to spend and you have left to the Congress to pare back the benefits. So you will be the good guys and we will be the bad guys.

One of the areas people are looking at increasingly is in the year 2000 when the benefit package they receive exceeds the basic minimum benefit package that it will then be constituted as taxable income. We are getting a surprising number of questions. What do you calculate the value of that benefit package in the year 2000 or projected to be, and what do you project the amount of taxable income will be from that package?

Ms. TYSON. I don't have those figures.

Let me say that there is another—you left out one administration official who could probably answer the question now, and that is the Treasury. What has been going on in the past three weeks in preparation for the legislative bill is adjustments, finalizing of the numbers.

The revenue estimates, the revenue issues concerning what will be the tax impact in any given year is being worked on by the Treasury. I don't have those numbers in front of me.

Mr. GUNDERSON. Would those be available next week upon introduction?

Ms. TYSON. I can find out and let you know. I assume that that issue is being looked at now.

Mr. GUNDERSON. Let's shift to a different subject. When you talk about 7.9 percent of payroll what do you calculate—is the average payroll wage or salary upon which you have arrived at 7.9 percent?

Ms. TYSON. What we have done here to arrive at this number is to look at the, what would be the case in 1994, given what we believe will be the payroll situation in 1994, and what we would, based on our actuarial estimates, believe the cost of the benefits package we are proposing would be in 1994.

Mr. GUNDERSON. What do you project the average wage would be in 1994? Most of the business community I talk to says if they can give that benefit package for 7.9 percent, they are very good, because most businesses don't think you can do that package for 7.9 percent.

Ms. TYSON. I think what you are saying is that business doesn't believe that we have priced the premium correctly.

Mr. GUNDERSON. Or they also calculate that you are doing this on a $36,000 average wage as opposed to say a $15,000.

Ms. TYSON. No. The issue is we take standard estimates of what payroll would be. We are not playing around with the denominator. Your question suggests that somehow you can get the 7.9 percent to look that level by inflating in an exaggerated way what you think is going to happen to payroll growth in this country.

Basically we took a standard projection of what would be the normal rate of growth of payroll in the country and then took a premium estimate based on actuarial assumptions done by two different agencies and HHS and signed off by an independent auditing group.

What people seem not to be willing to believe is can we get those basic benefits for that premium price. All I can say to you is that the HCFA actuaries, the AHCPR actuaries and an independent cost audit group said yes you can get it.

Mr. GUNDERSON. I am not contesting the process. I am simply trying to get 7.9 percent of what level of payroll equals this amount of money which we will have available in 1994 to buy the package? What is that level of salary you have projected?

Ms. TYSON. I now have a number for you. I want to emphasize it is absolutely consistent with what we currently see in 1993 just projected for the normal rate of growth of the economy for 1994. There are no tricks in this.

Mr. GUNDERSON. I am not accusing you of tricks. I am asking for a number.

Ms. TYSON. Payroll in 1994 we estimate will be $3 trillion. The number of workers is 120 million workers. That is $25,000 average per worker. Business spending on these services—well, we basically think—those are the numbers you asked for.

It is $3 trillion of overall payroll, 120 million workers averages to $25,000 per worker.

Mr. GUNDERSON. So we are at 7.9 percent of $25,000 times 120 million would then equal the amount of money you people believe will——

Ms. TYSON. You have to be careful here because the 7.9 percent—again this is not a payroll tax set at 7.9 percent for every firm. That is a misunderstanding of what is being proposed. Firms in general will be asked to pay a certain money contribution to the cost of insurance for their employee.

If they are employing a single individual, it will be about $1,500. If they are employing an individual in a family with children, it will be about $2,500. But some firms will be capped; that is the most that any firm would pay would be 7.9 percent.

Some firms will pay considerably less than 7.9 percent. Some firms will get a discount that will bring them down as far as 3.5 percent of payroll. So it is not appropriate to think of the 7.9 percent as an on average number. It is appropriate to think of it as essentially the most a firm would be capped at that, but some firms will be below that.

If you start off with a payment per worker depending upon the family status of the worker, obviously the payment will differ by State because we have—we are starting out with very big dif-

ferences in the health care costs of providing the same services in different States, but that is the way to think of this.

Mr. GUNDERSON. Thank you.

Chairman WILLIAMS. Mr. Green?

Mr. GREEN. Thank you, Mr. Chairman.

Dr. Tyson, let me make a brief statement. I understand the 30-hour week, because I have experienced for many years a less than 40-hour week in a union contract. A number are much less than 40 hours a week, 35 or 37½. So I can understand why the 30-hour week is in there instead of the 40 hours.

The concern I have—and I haven't signed on to the President's plan because I know there are other options—the more I hear of the other options, the President's plan looks better. One, you had to spend yourself into bankruptcy before you would receive assistance at all. That is one plan that I read about, which causes problems because we can do that under our current plan. People can spend themselves into bankruptcy right now and then they will be eligible for medicaid.

Another plan offered is a health care savings account which has some type of provision in there. My concern about that is again that is available now in the free market system. I can go out as an individual and my experience as a manager of a 13-employee firm who is responsible for the health care insurance is that we can do that now but I don't see that as a market force now being used. But also how would that control cost or slow the growth of the premiums.

My last question follows up on some from the minority side: How would these students—and there is great testimony in a few minutes from a mother whose 24-year-old son experienced a tragic illness—how would students and these early retirees be paid for by the security plan?

The health savings account is the first one. Is that really a market force that we can use?

Ms. TYSON. I think the problem with the health savings account is that basically it doesn't do—we have specified a number of fundamental goals and we don't believe the health savings account accomplishes any of the goals. It certainly doesn't accomplish universal coverage. It certainly doesn't accomplish any cost control. It doesn't give the individual any ability to gain bargaining or negotiating power vis-a-vis the insurance industry.

One of the problems we are trying to solve is that individuals and small businesses have really been, to my mind, the most—suffered the biggest burden from the current system because the cost shifting that goes on. The buck stops with the insurance premiums of the small business or individual self-employed person who cannot get an affordable rate and is often uninsured simply because there is no possibility of getting an affordable insurance policy.

So we don't think the savings account approach handles any of the goals that we believe are absolutely critical to getting costs under control, to getting universal coverage, and to making sure that in the marketplace individuals have a choice that is not as you pointed out a catastrophic choice.

It doesn't lead them to put off all their health care until the only problem is the catastrophic one where they have to use it. I think that that is the answer to that part of your question.

As far as students are concerned, what we propose is that if the student is full-time and less than age 23, they would be covered by their parents's plan, so the parent's plan if you are a single parent or in a two-parent household you are paying for a premium by the family of the employer which would cover the student.

If the student is over 23, they would be covered independently as their own family, meaning that they would pay towards their insurance. If they had any income at all as part-time employment, their employers would be paying something towards their insurance and of course available to them would be substantial amounts of subsidies to make sure that given whatever their income is as a student, they could afford to get coverage.

So coverage would be guaranteed to students. The difference is in age, whether you come off your parents' insurance policy and go into your own.

If you are a non-worker, there will be clear limits on how much you have to pay. If you work part-time, your employer will be paying something towards it.

Was there a third point?

Mr. GREEN. Yes, on the retirees and both the over 23, for example, the example we will hear about is a 24-year-old student, but also the early retirees, people who are 50 years old and retired either voluntarily or involuntarily; are they still going to pay for the 20 percent?

Ms. TYSON. Yes, based on their income. I think the simplest way to think about this is basically a family or an individual who will constitute a family will make some contribution towards the 20 percent up to the full 20 percent and that contribution will depend on the income of the individual or family.

So we have a standard rule whether you are a full-time worker, part-time, a student over 23, you will be making a contribution towards the 20 percent. The extent of the contribution will depend upon your income.

The first thousand dollars you pay nothing and basically you get a set of subsidies that are phased out if your income is 150 percent of poverty or higher.

Mr. GREEN. We have also examples of parents because of their job pressure who will refuse to have their children who are between 18 and 23 to be covered by their employer, for example. They may say we believe that students over 18 are students at a college somewhere else and not covered.

Will we see employers saying "I am not going to hire this person because I am going to pay more for them," and encourage an employee to say, "My 19-year-old is a student in California, even though I live in Texas?"

Ms. TYSON. The issue is not where the student lives. The issue is if you are an employer and you employ someone who has a student under 23, you will contribute something to their insurance.

Mr. GREEN. You don't have a waiver?

Ms. TYSON. Not in the current design.

Chairman WILLIAMS. Mr. Hoekstra?

Mr. HOEKSTRA. A firm in my district, a progressive firm, an automotive supplier, has over the last number of years made a significant investment into wellness programs, for example by encouraging their employees to stop smoking and exercising.

They built a major wellness facility including about 2,400 employees. Through these aggressive wellness actions and activities, they are providing basically a Fortune 500 plan, which I think would be equivalent to what you are talking about in the package, and they are providing it at about $2,600 per year because their employees are healthier than employees of other firms.

The company I worked for right down the block provided a Fortune 500 plan at roughly the amount the administration is talking about. What happens to the firm that has aggressively gone after health care costs, saw that by getting their health care spending under control, it would have a competitive advantage, and have done that? What happens to them under this plan?

Ms. TYSON. Without knowing more of the specifics, I can't give you a complete answer, but I can tell you a number of things about this. I would hope and I would assume that this firm would be better off in our system.

First, let me tell you that what we are trying to do in a way is to learn from the experiences of excellent firms like the one you described. We are trying to make available to firms regardless of size that option.

Many excellent employers, well-intentioned employers, simply cannot afford to do with the current insurance they face the kinds of things which your firm did, so we would like to give more firms the ability to offer the kind of wellness programs that you are talking about, the kinds of preventive programs you are talking about are in our package.

We have said this is what will bring down costs for everyone. That is what all firms should have the right to by having the ability to compete. Right now all firms do not have the ability to compete effectively in the insurance market. We are learning from that firm, I would say.

Secondly, even though that firm has been able to by dint of its own energy and sense of what health is, be able to come up with a very good plan. They are at risk because they are embedded in a system in which costs shift. They shift on to firms like that. The care of the uninsured keep premiums for that firm on average at 10 percent above what they would otherwise be. That firm is paying more than it would have to pay if everyone else were insured.

The good insured firms are systemically suffering from the fact that we have uninsured. Although that firm may be doing well this year or last year, over time if we don't get health care system reform they are going to see the cost of that program continue to escalate because providers will move on the cost of covering the uninsured in the form of 10 percent that can't buy insurance. So we are trying to benefit from that firm and learn from its experience.

Mr. HOEKSTRA. I understand that firms like that would be buying the same standard package. Are you saying that one firm of 2,400 employees would be buying the package at one price and another firm with a same number of employees could be buying the same insurance for less?

Ms. TYSON. The preventive part of it will be available to all firms. That is what I am saying. Basically as the system will work, your firm, which was 2,400 people, in the current proposal where self-insured starts at 5,000, not at 2,400, that firm would be in the alliance. That firm would therefore have as an option one of three plans.

What I was suggesting was those three plans, what is in those three plans includes things I would suggest probably everything that firm is offering.

Some people say why have you designed your benefits package to be so generous—a very important part of the answer is because a more generous package may ultimately be a less costly package because if you get people into preventive medicine and wellness programs, then they don't use the most expensive part of the system because they don't need it. So your firm would be in the alliance, but I am suggesting your firm would end up having a choice for its employees at least as good as the choice being offered.

The one drawback to your firm perhaps, and I don't know this for sure, but to make sure that everything is out there, this is a community-rated proposal we are making. So that a firm which has very healthy young workers may be able to on its own get a better price for that package than it would in our system. That is part of saying that people are going to be insured their whole life and though some workers may end up paying more when they are young, they will end up paying much less when they are old under our system.

So over the lifetime of the firm and of the employees, we believe the costs will be lower.

Chairman WILLIAMS. Mr. Klink?

Mr. KLINK. Dr. Tyson, I want to shift the questioning, if I can. My district is in western Pennsylvania near Pittsburgh. Counties in my district were once very heavy manufacturing. Now, however, things have changed and the number one industry happens to be health care. So I am concerned, I don't want to go through what we went through in the steel mill shutdown with health care reform. I am going to relate this to jobs and try to find out how this is going to affect people in our area.

One of the groups that have talked to me, we have a Chairman kind enough to let us hold a hearing on health care in my district a week before the President made his health care speech on September 22. One of the groups we heard from were nurse practitioners. I have heard from nurse practitioners that are afraid because they have been able to do so much for so much less that they are going to be shut out rather than included in health care that is provided.

What kind of assurance can you give me that nurse practitioners will be an inclusive portion of the system?

Ms. TYSON. It seems to me that is one of the things—I talked about the importance of incentives and I tried to emphasize that I believe that there are a lot of possible savings in the health care system we currently have, and the reason we are not making use of savings is because there is not the right incentive.

Under the capitation system we are proposing where basically insurance deliverers of health care services will get a certain pay-

ment per person that they serve, there is a tremendous incentive to reorganize care in the most cost-effective manner possible. We want the incentive to be there not to reduce the quality of care, but to reorganize for the most cost-effective methods.

Nurse practitioners in this situation it seems to me would be an extremely cost-effective way of delivering care. My experience with this is that I have as a matter of choice for more than a decade been involved with health maintenance organizations and nurse practitioners are an important part of those organizations because there are many things that they can do that under the current system there is no incentive to allow them to do this because there is incentive to use a more costly technique, a more costly provider.

So I think this is a benefit for nurse practitioners.

Mr. KLINK. Alternative forms of treatment, where do you see those people that are involved—how will they fit in and how do we give assurances that when these groups are put together that the nurse practitioners that have been proven to be cost effective are still going to be part of the mainstay health care system?

Ms. TYSON. The primary way we do this is by setting up the incentives to have it done. The drawback to the current system is that we don't have enough incentives in place to encourage individuals or providers to come up with the least costly way of getting a good result. So overall the system works to encourage these alternatives.

Presumably over time, since medicine is somewhat of an art and not a science, we would imagine that the National Health Board would make sure that the basic benefit package was defined in such a way to make sure that cost-effective alternative approaches to achieving the outcome were covered.

We would make sure that cost alternatives with proven records are covered in our plan. This will evolve over time through the National Health Board as well.

Mr. KLINK. Will these incentives be in the legislation?

Ms. TYSON. They are in two basic designs. We are—it is in the interest of the providers themselves to organize into networks to deliver care for the least costly way. Therefore I think the incentives are part and parcel of the whole program. The comprehensive benefit package will outline what services will be covered and what will not, but this will evolve over time.

One of the things that is not emphasized enough is how much we hope consumers and providers will learn from trying to reform the system. We have a proposal that each year each of the plans in an alliance provide detailed information to consumers about the performance of that way of providing so that you have information about how long it takes before you see a provider, what kind of provider you see and various indicators of health outcomes. Presumably consumers who will see that one plan or the other has better performance will move towards those plans.

It is to the benefit of the providers to organize ways to get the best outcome for the cost. I would think it would help the kind of providers you are talking about.

Mr. KLINK. We had a technology report issued in 1990 which indicated we had 43 MRIs in the 6 counties around metropolitan

Pittsburgh. At the same time in all of Canada, there were only 25 such machines.

How is this reform proposal going to address this situation?

Ms. TYSON. I think the issue is incentives. We have a substantial amount of evidence that there are MRI machines around the country that are very underutilized, that the current system we operate in is one which provided an incentive for providers, for hospitals to invest in, provided the means for them to invest in MRI machines which are essentially being underutilized.

When a resource is underutilized, it is either wasted or the providers charge high fees when the resource is used to try to make up the revenue they had to invest to get the machine. We believe we can see, and the HMO experience is an example, to suggest that when it is in the interests of providers to try to find a least-cost alternative for providing the same quality care, there may be less use of these machines.

This is a kind of machine which there is a fairly large body of evidence suggesting inappropriate or unnecessary use which in the current environment is the right thing to do. If you have a machine and it is not being utilized and you can get somebody to pay to utilize it, it is used.

How many of those machines there are and how often we use them will be judged on whether it is efficient and appropriate to use it?

Mr. KLINK. May we submit questions in writing?

Ms. TYSON. Sure.

Chairman WILLIAMS. Mr. Ballenger?

Mr. BALLENGER. Thank you, Mr. Chairman.

One of your statements showed preliminary estimates that businesses depending on health care will fall by $10 billion. Are there actual figures that you came with or did somebody say there is going to be a 10 percent savings and you go back to $3 trillion and come out with your simple formula to produce that?

You mentioned three separate plans that are going to be available, but how can anybody figure what the costs are going to be? As far as we are concerned, nobody knows what the plans are.

Fortune 500 plans, if there are 500 companies on the Fortune 500 they probably have 500 different plans. It seems to me that we are being very nebulous in our approach. Since we are going to change the whole world and the way it operates, it seems we ought to be able to get tighter figures, like how much is it going to cost to establish alliances or the reviewing of drug prices, all the stuff that goes into costs. Mr. Armey should be here—he is an economist type folks—that you can come up with percentages and so forth by the practical approach to what the actual costs are——

Ms. TYSON. Let me say that I think you need to understand costs in two different ways.

Mr. BALLENGER. Let me preface this. I have been buying health insurance for my employees for 40 years so I do have a little experience in how it works.

Ms. TYSON. We did the following: We specified a comprehensive benefits package——

Mr. BALLENGER. Is it specific?

Ms. TYSON. Very specific in terms of what is covered and what is not covered and it is based largely on the best practices of some large companies, but also of some 2,400 companies who have done very well by designing a comprehensive package. So we started out with a design of a comprehensive package which is very detailed in terms of what will and will not be covered.

We then asked actuaries from inside and outside the government, including some actuaries from companies themselves, to price out the package, what would it cost to buy such a package in 1994. If you were to buy it next year, what would be the cost? We came up with a set of costs.

We would like to see where it is possible a State or a regionalized offer, three different ways of providing those services. The services don't change, but networks of providers can organize differently to provide those services. One possible way of providing it is a health maintenance organization. Another is a preferred provider organization. Another is a fee-for-service plan.

We asked the actuaries to price out the same basic services, but delivered in three different ways. So then we had three different cost estimates, one for each of these three plans. We then asked ourselves—so let me say that those kinds of estimates I believe are really not very controversial.

We have a series of actuaries inside and outside the government saying that is pretty much what it would cost.

Mr. BALLENGER. Can we see the plan?

Ms. TYSON. You will see the plan next Wednesday. So the controversy should not be I believe about those numbers. If there is going to be debate, the debate is about how fast do we think those premiums will grow over time, at what rate starting from 1994 will those costs escalate?

We could predict that in the current system. There are lots of predictions about what will happen to health care costs if we don't reform the system. It is harder to say at what rate do we think the premiums will escalate if we reform the system.

Here we had to draw on a wide body of evidence. We did build into our figures an amount of money for administration of the new system. We believe on balance it is a saver of money on administration because the current system of paperwork and alternative plans places a very high burden on providers and on users. So we believe there will be a net reduction of administration costs, but we certainly didn't put them to zero.

We have some money in for administration. So administrative costs we believe will go down. We believe there will be a reduction in fraud and abuse which the current system is set up to encourage.

We believe because consumers will be more cost conscious, they will shift towards certain plans which over time generate the same services in a least-cost way and finally, providers should be more cost conscious in our system because we are essentially saying that that is what the global budget is, ultimately a target, saying to providers we believe there are ways based on the evidence we have looked at for you to deliver the same service at a slower rate of cost and that is the incentive for them to do it.

Mr. BALLENGER. The basic thing the savings that are built into medicare because—most hospitals are slowly but surely dying because of the way the medicare system operates. They are getting paid substantially less than it costs and yet are we going to take a system that is broke, namely medicare, and somehow change it into some substantial way so that we can save $124 billion or some crazy number like that?

Ms. TYSON. There are going to be some specific proposals about what our medicare savings would be. There are a couple of examples that I think make them sound realistic.

Number one, there are some people who get medicare now who are employed. Now under our system, their employers will make some contribution to their coverage, so it will no longer only be Federal dollars covering the medicare contribution, it will be employer and employee dollars.

You and your employer under our system will contribute to your medicare coverage. That will be a savings on medicare.

Secondly, in medicare and medicaid we have a situation in both cases where because of uncompensated care issues, these rates that for medicare and medicaid include payments to hospitals to cover part of their uncompensated care bill—so that will be reduced, the uncompensated care bill will be reduced because people will be covered.

You have to think we are bringing into the system more employer and employee funding of the system so that is going to take some pressure off of the Federal system. We are also going to ask for an increase in Premium B payments by higher income individuals.

We are also going to adjust reimbursement rates. You can look at all these proposals and I believe they will be fully debated, but I think some of the savings we are looking at here come precisely from taking payments currently being made through medicare and medicaid and having them come through employee and employer contributions and reducing the burden on the whole system from uncompensated care.

Chairman WILLIAMS. The time of the gentleman has expired.

The Chair would note that while there are some details not available understandably because of the legislation system here, yet the detail with regard to the benefit package has been available for some time in the book that each member has before them. In fact the only major plan before the Congress that has a detailed and available benefit structure is the President's plan.

The other major plans leave the benefit structure to the National Board. You don't know what you are going to get until the board decides and tells us.

Mr. Reed.

Mr. REED. I would yield to Mr. Payne.

Mr. PAYNE. Thank you, Mr. Chairman.

Let me commend you, Dr. Tyson, for the very interesting dialogue we have had here today and I think in general to commend the administration for bringing this important issue to the American people because until now I think very few people have had much knowledge about health care.

Most people don't even know the other person's doctors; therefore it has been a system that has grown out of control, unregulated because no one really knew what the other person was doing. It is probably the only industry where that cloak of secrecy almost seems to exist—higher education or other areas, everyone knew how much it costs to go to the University of Michigan as opposed to Rutgers in New Jersey.

With the doctors, it is confidentiality—so I think that the biggest achievement to date is waking up the American people about this thing that is taking 10, 12, 14 percent of GDP annually. Therefore I think that there are a number of problems.

I don't know of two parents who are working, who take the children under their care. Right now one of the additional costs that hasn't been brought out much is that both of them share the costs which is a waste on the premium side because if they both have coverage, then both take the coverage. So there has to be some way to eliminate the duplication and I suppose you know how to do that.

I think that we need to take a look at some of the less expensive methods. I don't know where midwifery stands, but when you take the cost of a midwife in a delivery as opposed to the traditional way, you find that there is a tremendous difference, I wonder where that comes in.

The other issue with using HMOs is that HMOs are great for healthy people, for people who are working and for people who would like to pick and choose. They were healthy people that primarily went to HMOs. I wonder if the HMO experience is not jaded by virtue of the fact that it didn't reflect what Americans wanted.

I cautioned the administration and as we move towards a position of attempting to get wellness, for example, talking about women and mammography and so forth, trying to get women to get into the system of doing it, talking about clinical tests, perhaps a prevention of breast cancer on one hand, but on the other hand coming up with a statement that until you are 50 you really don't need mammography but once every three years.

I think it is somewhat conflicting and damaging as we are moving towards trying to upgrade women's awareness of mammography, on the other hand, when really no valid tests were done in the United States, they looked at Sweden and Canada and Australia and talked about it in Geneva—that to me is damaging.

We need to bring everyone up—I support H.R. 1300, universal health care, but that is not going anywhere yet—but I hope that we don't in some critical areas reduce what is necessary or right so that it conforms with what the plan says.

Ms. TYSON. I agree on the need for people to be informed about the health care system. I think one of the things that is happening here—there are a number of misconceptions. One is that it doesn't matter if somebody is not insured as long as you are insured. That is simply wrong because if you are insured, you are paying for the uninsured.

Another misconception is that the uninsured are not employed. We know that most are in families with an employee. It seems to me that there is a tremendous lack of information about health care outcomes. The plan is designed to make sure that we have

well-informed consumers so consumers have a choice. Whereas now if you are in a firm of 500 or fewer, you are likely not to have any choice at all, you have one plan, take it or leave it. So it is very hard to be an informed, cost-conscious consumer in that world.

I think information is critical to making good choices and to competition. If you read textbook models of competition and how it works, the first assumption is that market information is available to a consumer. I consider myself a well-informed consumer and an intelligent individual, and I don't know much about my health care plan, and no one is there to tell me, certainly not in terms of longitudinal studies about its comparative performance versus an alternative that might be available to me.

So I think information is a very important part of what is going on.

On the HMO situation there was a study referred to yesterday in the newspaper by GAO on HMOs. We have not yet had a chance to evaluate the study but we have evaluated studies including the CBO study, which concludes that HMOs really can reduce costs by 10 to 15 percent. If you put an HMO structure into each alliance, then what that structure is going to do is exercise competitive pressure on the alternative providers to meet their standard of cost consciousness.

So we look at individual HMO experiences and say "If they are going costs, imagine putting environment." I would suggest they will have an even more salutary effect on costs over time.

Let me say that medicine, your mammography example demonstrates that medicine is not as precise a science as doctors would like it to be, and doctors are the first ones to tell you that. What we have right now is a system of incentives whereby without having very much knowledge about whether a particular procedure is necessary or appropriate or has any effect on health outcome at all, the incentive is to use it because the system pays for it.

What we hope to set up is a system which over time will generate more information about which procedures are necessary and which are not. The only way to generate that information is to put in place an incentive to look for the information, and right now there is not an incentive to look for the information.

Chairman WILLIAMS. Mr. Reed?

Mr. REED. Thank you, Mr. Chairman.

Dr. Tyson, I don't mean to be redundant. I think others have asked a similar question. Could you elaborate on the assumptions and analysis that led you to conclude that the increased per-hour cost of the health care plan to business is 15 to 35 cents?

Ms. TYSON. That 15 to 35 cents an hour is a particular number and it comes from asking the question for a small—we designed a discount arrangement, taking into account that most workers in our society are already covered by their employers. The workers who are most likely not to be covered by their employers right now are low-wage workers in small firms. So we wanted to design a price to cover those low-wage workers in small firms which would not make a significant difference to the cost of employing such a worker in such a firm.

So our discount of 15 cents to 35 cents really reflects the price per hour of providing insurance, our comprehensive benefit package

in a low-wage firm who is receiving a discount, meaning that its overall spending on health insurance would be between 3.5 percent of its payroll and 7.9 percent of its payroll. That is where the numbers come from, from discounts for particular firms based on their size and their average wage.

Mr. REED. So essentially you are talking about those firms that—the 7.9 percent I assume is the cutoff for all firms?

Ms. TYSON. That is a cutoff for all firms.

Mr. REED. The low number was the lowest payroll that you pay with the lowest workforce, et cetera?

Ms. TYSON. Right. You are phased up to 7.9 depending upon your size and average wage.

Mr. REED. Are you saying then that the range of increases in per-hourly wage attributed to the plan would be 15 cents to 35 cents corresponding to the top 7.9 percent, the cutoff point and the lowest subsidy point?

Ms. TYSON. I am saying—that amount is really—you have to take into account that some firms will just—I think I want to start it backwards, start from the beginning. The basic principle we started with was that firms should make a contribution of 80 percent based on 80 percent of the average plan for each employee. That means for an employee, a single employee, it is about $1,500 in 1994 and about $2,500 if the employee is part of a family with children. That is basically the setup.

We said we want to make sure that firms who are—that firms won't ever go beyond a certain percentage of their payroll. Either you basically are capped at 7.9 percent, that is the most of your payroll that you would ever have to pay.

What that would mean to the cost of your workforce, we know it is 7.9 percent of your overall payroll—what it means on the hourly pay of any individual worker——

Mr. REED. I understand. In the aggregate then, that is a reliable indication of what the typical low wage company, say a restaurant that provides no health care insurance, almost minimum wage, that the range of increased cost per hour they can see is 35 cents?

Ms. TYSON. That is right. That range of accounts is addressed for those workers.

Mr. REED. Would you provide a more detailed list of assumptions?

I have heard initial reactions to this plan from those industries we were just discussing. They are saying, this is going to bankrupt me, I work in a small market, et cetera. Yet that statistic, when you break it down, is generally what they are talking about for a raise next year.

Ms. TYSON. It is generally what they are talking about for a raise——

Mr. REED. If I can get to another question. In your calculations, have you made a determination of excess capacity in the health care system today and more importantly, I think, have you made estimates as to what happens with excess capacity as you start bringing down the budget ceiling?

I love economic jargon because you can say mean things in a neutral way. There will be lots of hospital consolidations—that is what I am getting at. Could you elaborate?

Ms. TYSON. I think we only have an aggregate elaboration in the following sense. We are bringing down the rate of growth of health care spending over time but remember, the initial thing we are doing is adding more health care spending to the system, we are bringing more people into the system.

So you have a situation where you have more spending and then a slowdown in rates of growth of spending. Spending does not fall absolutely. This is not the equivalent of defense conversion where we are cutting spending. We are slowing down the rate of growth.

There will be some hospitals, we know there are hospitals with substantial amounts of excess supply of beds who presumably will find it even more difficult to fill those beds.

One of the things we know is that right now the more hospital beds there are the more they are used. It is quite a remarkable feat, and I think that we will end up with probably some hospitals having some difficulty. But at the aggregate level, we are talking about more spending.

In most hospitals, we have an occupancy rate of 67 percent so we already have a substantial supply of hospital beds around the country.

Mr. REED. That analysis projecting forward about costs I presume incorporates the notion that some of this excess capacity will be eliminated?

Ms. TYSON. I think the idea is to leave to the providers, the hospitals and the doctors the way to figure out how to adjust to changed structure. Some hospitals will be restructured and some may indeed be closed.

Mr. REED. Thank you.

Chairman WILLIAMS. Dr. Tyson, thank you very much for being with us. You have been specific and very helpful. We appreciate your accepting our invitation to come by.

Ms. TYSON. Thank you very much. I appreciate it.

Chairman WILLIAMS. We will ask our first panel to come forward now, those who are members of our first panel.

We will begin with Kathleen Slezak from Toledo.

STATEMENT OF KATHLEEN SLEZAK, TOLEDO, OHIO

Ms. SLEZAK. Good morning, Mr. Chairman, and the few members of the committee who are left here today.

Chairman WILLIAMS. Let me interrupt to remind each of you that we have a five-minute rule so we would appreciate it if you would try to keep your testimony within five minutes.

Ms. SLEZAK. Thank you for inviting me to testify today. I am Kathleen Slezak. My husband Terry and I live in Toledo, Ohio. We have three children: Jeremy, who is eight years old; Alexandra, who is four; and Kathryn, who is 22 months old. I want to make the facts and figures of estimations of Laura's testimony come to life as I tell you about the four-year nightmare we had to endure while we did not have health insurance. It was an experience that millions of Americans are subjected to every day and I wouldn't wish it upon my worst enemy.

My husband Terry worked for 10 years as a regional manager for a company that sold beauty supplies to salons and barber shops. The employer paid for our family's health insurance coverage until

May of 1989. That is when Terry was laid off permanently due to company cutbacks. We couldn't afford the $300 per month to continue our family coverage under COBRA. At the time, I was not employed outside of the home because it didn't pay enough to offset the cost of child care for two children. We were forced to gamble with our health and we lost.

Terry began looking for work and in 1½ years' time landed a few temporary jobs. However, they didn't provide health insurance, let alone a reasonable salary. He ended in the unemployment line for nearly seven months. During that time, in December of 1990, Terry developed a serious heart condition, cardiomyopathy. He was only 32 years' old. Unless this condition is controlled, people with the problem develop congestive heart failure, the body swells with fluid, your blood pressure rises, the heart rate increases to accommodate the body and blows up like a balloon. This disease is often fatal.

Terry hadn't been feeling well for a while, but because we didn't have insurance and couldn't receive medicaid benefits, he put off going to the doctor. His worsening condition finally convinced him to go. He was misdiagnosed as having TB and then pneumonia. The medication prescribed wasn't working, but we couldn't afford antibiotics or testing or another doctor visit to find out what was wrong.

I will never forget Christmas Eve of 1990 when he came into the kitchen and plopped into a chair and sat down and said, "This is very gruesome, but I feel like somebody who knows they are getting ready to die."

At that point, he said, "Screw the bills. We are going to the emergency room and worry about the bills later." So we rushed to the hospital, where the emergency room physicians later told us that he was hours away from death. Terry was hospitalized for five days hooked up to wires and monitors in the cardiocare unit until his condition stabilized enough to send him home.

When he was discharged, our doctor placed him on a heart transplant list in Medical College of Ohio and diagnosed him as being disabled. There is no cure for this disease.

What I thought would be a quick emergency room visit ended up changing our lives forever. To control his condition, Terry has to visit the doctor every three months for a blood workup and an exam. Together these cost us approximately $140 every three months. In addition, he has to take five separate medications which total over $100 dollars a month. We cut costs by buying generic drugs when available and our doctor has provided us with samples.

We currently qualify for a program with one particular pharmaceutical company that provides us with one of the prescriptions. On top of this, Terry needs to take medication which costs $50 a month for clinical depression, which he has had for years.

Of course, while we were uninsured, we had to pay all these costs out of pocket. Four months after Terry's hospital ordeal, after applying twice for social security disability benefits and being turned down and two weeks before unemployment benefits exhausted, my husband found a position with another beauty supply company that provided health insurance to its employees. However,

because of his preexisting condition with the cardiomyopathy, the entire family was turned down for health care benefits.

We had no way to pay off our excessive medical bills. We were forced to go to Terry's former employer and cash in his pension plan which he received upon proving his disability.

After taxes, we had about $10,000 to use for medical bills that kept the collection agents from our door. The following month we had the surprise of our lives. I became pregnant with our third child, Kathryn. I did not qualify for medicaid at the time. Fortunately, however, my OB–GYN doctor waived the usual $2,000 fee for prenatal care delivery and 6-week checkup due to our qualifying under a private program funded by the United Way. Nonetheless, we have to pay $2,000 to the hospital and its employees for a normal vaginal delivery with no complications and I was in the hospital for only 24 hours.

When I was five months pregnant, I returned to work as a hair designer to help pay our bills, which exceeded our monthly income. The company that hired me offered health insurance to their employees, but I would have had to pay the entire premium, which was $385 a month for family coverage. The deductible was $200 per person with no family limit and it was a basic 80–20 plan.

Obviously we could not afford to buy health insurance and pay our outstanding medical bills. As a matter of fact, I went back to work two weeks after Kathryn's birth.

When our new baby was only three weeks old, she stopped breathing and we called 911. I am embarrassed to tell you that I actually hesitated when the dispatcher wanted to send an ambulance because in the back of my mind I was thinking about all the bills that we had accumulated.

Even though she was breathing and crying and when the paramedics arrived, they urged us to take her to the hospital. We declined, but promised to contact our pediatrician the following day. Our pediatrician told us she needed to be put on a monitor for 24 hours. That cost us over $300.

Terry also has had two bad bouts that landed him in the emergency room. Those two visits collectively cost about $1,400. Between his heart condition, other hospital and doctor bills and my pregnancy, we had run up approximately $30,000 in medical bills in a short period of time, with no assistance from insurance or from the medicaid system which our tax dollars have been supporting for nearly 20 years.

Things are starting to look up for us. Terry's prognosis is quite good and his condition is controlled by medication and he was taken off the heart transplant list. In January 1993, Terry landed a new job that provided the family with health insurance coverage. We pay half of the $300 premium and it is a good 80–20 plan. Although no preventive health care is included, we are reimbursed for our prescriptions.

I have finally gotten care for my allergies, medical treatment that I put off while we didn't have health insurance. Our family has had a number of sinus infections and we could get the antibiotics and go to the doctor.

Terry did have to pass a nine-month waiting period before the new insurance would cover a heart transplant, which has now

passed. Thank God his condition stabilized enough that he didn't need the transplant during this time.

I still worry about what might happen to our family if we lost our health insurance again. I am also upset that we had to mortgage our future, use money we were saving to plan for our retirement, money that was to be used as a life insurance policy for my husband to cover the cost of these medical bills.

In the meantime, there are things that Terry and I would like to provide for our children that we have to forgo while we pay these medical bills.

I don't ask for much. We don't want a cottage on Lake Erie. We don't need a big fancy car, but I would like to be able to go out and buy shoes for my children when they need them or go out to dinner with my husband once in a while without having to jeopardize paying our regular and medical bills. Something has to be done now.

Please, I urge you today to put aside your individual differences and come together to create a health care program for the millions of Americans such as my family that you represent.

Thank you again for giving me the opportunity to speak with you today. I would be happy to answer any questions you might have.

Chairman WILLIAMS. Thank you.

[The prepared statement of Ms. Slezak follows:]

KATHLEEN SLEZAK

Good morning Mr. Chairman, and members of the committee. Thank you for inviting me to testify today. My name is Kathleen Slezak. My husband, Terry, and I live in Toledo, Ohio. We have three children: Jeremy, age eight; Alexandra, who is four; and Kathryn, who is 22 months old. I am here to tell you about the four year nightmare we had to endure while we did not have health insurance. It was an experience that I wouldn't wish on my worst enemy.

My husband, Terry, worked as a regional manager for a company that sold supplies to salons and barber shops. Up until 1989, the family had health insurance coverage through Terry's employer. That year, Terry was laid off from his job. We couldn't afford the $300 per month to continue our family coverage under COBRA. At the time, I was not employed outside the home. We were forced to gamble with our health, and we lost.

In December, 1990, Terry developed a serious heart condition, cardio-myopathy. He was only 32 years old. Unless it is controlled, people with this problem develop congestive heart failure. The body swells with fluid, the heart beats faster and blows up like a balloon. Terry hadn't been feeling well for a while, but because we didn't have insurance, Terry put off going to the doctor. Finally, his condition became very bad. I'll never forget Christmas Eve of 1990. Terry was hooked up to wires and monitors in the cardio-care unit, and the doctors told me that he was hours away from dying. It was terrible.

Terry was hospitalized for five days until his condition stabilized. When he was discharged, the doctors put Terry on the heart transplant list. To control his condition, Terry has to visit the doctor every three months for a blood work-up and an exam. These tests cost us at least $130 every three months. In addition, Terry has to take five separate medications. The total cost of these medications is well over $100 per month. We cut costs by buying generic drugs. The doctor provides us with samples, and we qualify for a program with one drug company that provides us one prescription. On top of all this, Terry needs to take medicine to control clinical depression, a problem he's had for years. Of course, while we were uninsured, we had to pay all of these costs out of pocket.

Four months after Terry got out of the hospital, I became pregnant with our third

child, Kathryn. I did not qualify for Medicaid at the time. My prenatal visits were covered by a private program called "First Call for Help/Medical Assistance," because we were uninsured. Nonetheless, we had to pay $2,000 for a normal vaginal delivery with no complications and I was in the hospital for only 24 hours.

When our new baby was only three weeks old, she stopped breathing, and we called 911. Even though she was breathing and crying by the time the paramedics arrived, our pediatrician put her on a monitor for 24 hours, which cost us over $300. Terry also had two bad bouts that landed him in the emergency room. Those two visits cost about $1,400. Between Terry's hospital and doctor bills, and these other problems, we had run up about $30,000 in medical bills, in no time. And we had no way to pay for it. Our family income for the year was only $6,000.

To help pay doctor bills, Terry started looking for work, even though he was still pretty sick. He landed a couple temporary jobs that helped out with the bills, but they didn't provide health insurance. He also worked for a time for another beauty supply company that provided health insurance to its employees. However, because of Terry's heart condition, the entire family was turned down.

I am a hair designer. When I was five months pregnant with Kathryn, I too, returned to work to help with the bills. The company that hired me offered health insurance to their employees. But I would have had to pay the entire premium, which was $385 per month for family coverage. We could not afford to buy health insurance and pay our outstanding medical bills!

We had no way to pay all of these bills. We had to go to Terry's former employer and cash in his pension plan. After taxes, we had about $10,000 to use for medical bills that kept the collection agents from our door. We were paying a little on these bills every month, sometimes as little as $5.00 per month. Even after we used Terry's pension money, we still owe about $10,000 in bills.

Things are starting to look up for us. Terry's prognosis is quite good. His condition is controlled by medication and the he was taken off the heart transplant list. In January, 1993, Terry landed a new job that provides the family with health insurance coverage. It's good coverage. We are reimbursed for our prescriptions, and I have finally gotten care for my

allergies -- medical treatment that I put off while we didn't have health insurance. Our family has had a number of sinus infections this year, and we could afford the antibiotics the doctor prescribed. Terry did have a nine-month waiting period before the new insurance would cover a heart transplant, which has now passed. Thank God his condition stabilized enough that he didn't need the transplant in that time.

I still worry about what might happen to our family if we lost our health insurance again. I am also upset that we had to mortgage our future -- use money we were saving to plan for our retirement -- to cover these medical bills. In the meantime, there are things that Terry and I would like to provide our children that we have to forego while we pay these medical bills. I don't ask for much. But I do want to buy my children shoes with they need them, or be able to go out to dinner with my husband just once in a while. I hope no one else has to confront this kind of nightmare. Something has got to be done.

Thank you again for giving me the chance to talk to you today. I am happy to answer any questions you might have.

Chairman WILLIAMS. Our next witness is Florence Corcoran here with us from Louisiana. Thank you for traveling here.

STATEMENT OF FLORENCE CORCORAN, ON BEHALF OF VOICE, VICTIMS OF INSURANCE COMPANIES ERRORS

Ms. CORCORAN. Thank you very much for letting me testify today before the subcommittee. I would like to thank you personally for sponsoring the bill H.R. 1881 and hope they will be remedies resolved under ERISA.

Good morning. Thank you for allowing me to testify before your subcommittee today. My name is Florence Corcoran and I work for South Central Bell Telephone Company in Louisiana. I am here on behalf of VOICE, Victims of Insurance Companies Errors, which is a nonprofit grassroots organization dedicated to health insurance reform.

We want to see meaningful protections written into law so when health insurers fail to live up to their promises, we face not a black hole, but a system that makes sure we get all of the medical care we need. We also want to make sure that, when people like me are denied appropriate medical care, someone is held accountable and that fair claims procedures are available.

I thought I had good health insurance that my union, the Communications Workers of America, bargained for until I really had to use it. In 1988, I had a high-risk pregnancy which required me to be hospitalized for several weeks before I had to have an emergency C Section, because my baby went into fetal distress. Fortunately, my health insurance plan was willing to pay for the hospitalization and as a result I have a healthy five-year-old daughter named Amanda.

The system worked. The doctor said I needed the care and the insurer paid for the proper care. The following year, in 1989, because my insurer denied me my hospitalization benefit for another high-risk pregnancy, instead of there being a happy ending, I suffered a tragedy that still haunts me today. My unborn baby of eight months died unnecessarily because I was denied proper medical care.

I thought I had the same good health care coverage and therefore I thought I would get all of the proper medical care I needed as with the previous high-risk pregnancy.

My story is not of a person being uninsured or underinsured, I had a good union-bargained health plan that supposedly provided coverage for all needed hospital, physician, and other medical care. But the end results were that a utilization review board, thousands of miles away from me, could make life-threatening decisions about my care without ever seeing me.

This so called medical utilization board only had clerical staff LPNs and RNs making medical decisions. They overruled my own doctor who was treating me day in and day out and has a medical degree.

My doctor determined that I had another high-risk pregnancy and needed to be hospitalized as I was the prior year when I was monitored by the machines and nurses around the clock. During the previous pregnancy, I was in labor and delivery for two weeks

being watched day in and day out in case the baby went into fetal distress.

Two weeks into my second hospital stay my insurance plan informed my doctor and the hospital that they were cutting off my medical coverage due to the fact that they felt that I could get the same type of care at home that I was getting in the hospital. They overruled my doctor's advice and orders and the only thing he could get for me was a home health nurse to come to my home a few hours a day to check on me.

I only lasted at home two weeks before one night my baby went into fetal distress without me knowing. With no one monitoring me, my baby died while I was eight months pregnant.

You can't tell me that with the same high-risk pregnancy back to back that the insurer the second time around decided it didn't want to have to spend the money it did the first time and so made an economic decision to deny me my needed hospitalization. The bottom line was dollars and cents not my well being and health care.

I was forced out of the hospital and told my medical benefits were being cut off. I felt at that time I had no recourse because they always stated they had our best interest at heart.

Because my supposedly good health plan denied me proper medical care. After taking my insurer to court and then appealing the decision in the Fifth Circuit Court of Appeals I learned ERISA preempted State law from applying to my case. In effect, the insurer got away with murder and will never be held accountable, but I have to live with the consequences for the rest of my life. ERISA, a law designed to protect people like me, instead protects insurers from being held liable in cases of wrongful death.

The judges of the Fifth Circuit Court of Appeals stated they sympathized with me and that a grave mistake may have been made, but that my only remedy was to get Congress to change the law.

What are the lessons to be learned from my tragedy? My baby died and nothing can bring him back, but my only wish is that no one has to go through what I went through and now have to live with for the rest of my life.

Lesson one: The Clinton Health Care Plan must promise more than a laundry list of medical benefits. People must be able to actually get the benefits. Access to care should be based on medical need and should not be based on economic decisions.

Lesson two: The Clinton Health Care Plan must allow doctors' decisions to be the final word in patient care and health plans should have to give their decisions proper weight. Utilization review boards should not be able to overrule doctors' medical decisions. Utilization review boards should not be allowed to simply add another layer of bureaucracy between patients and their doctors. They should not be allowed to make life threatening decisions from thousands of miles away without ever seeing the patient.

Lesson three: Health plans must be held accountable for their decisions. The Clinton Health Care Plan must not allow health alliances or health plans to make what amounts to economic decisions without having to pay the consequences for those decisions.

Lesson four: The Clinton Health Care Plan must provide fair claims procedures when health plans unfairly deny coverage and

claims. No health plan should be able to get away with murder like my insurer has. Either there must be new remedies created under ERISA or under the Clinton Health Care Plan that allow people like me to sue in wrongful death cases or when coverage and care is denied.

Lesson five: Meaningful remedies must include more than the ombudsman that the Clinton Plan is now talking about. People must be able to get quick decisions when life-threatening situations arise. At the same time there should be penalties set in place when insurers deny appropriate medical care within a certain timeframe. People should be able to go to court when insurers deny legitimate medical care and the insurers should be held accountable and have to pay punitive damages when they are truly negligent.

No amount of money is going to bring my baby back, but if the insurers had to pay punitive damages for their economic decisions in denying proper medical care they would think twice before making a life-threatening mistake again.

Currently, because insurers are not held accountable and do not have to answer to anyone, tragedies like mine have occurred and will continue to occur. Insurers should not be allowed to get off scot-free without being accountable.

Again, thank you for allowing me to testify before this subcommittee. I would be happy to answer any questions you might have.

In closing, I would like to show you a picture of my baby. It was eight months. This is his death certificate, and nobody got held accountable for him. I want you to try to change ERISA so that these people don't get by with this. I am sorry.

Chairman WILLIAMS. Thank you. Thank you for being with us. I know this wasn't easy for you, but your testimony is helpful.

[The prepared statement of Ms. Corcoran follows:]

FLORENCE CORCORAN

Good morning. Thank you for allowing me to testify before your Subcommittee today. My name is Florence Corcoran and I work for South Central Bell Telephone Company in Louisiana. I am here on behalf of VOICE, Victims of Insurance Companies Errors, which is a non-profit grassroots organization dedicated to health insurance reform. We want to see meaningful protections written into law so when health insurers fail to live up to their promises, we face not a black hole, but a system that makes sure we get all of the medical care we need. We also want to make sure that, when people like me are denied appropriate medical care, someone is held accountable and that fair claims procedures are available.

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The following year, in 1989, because my insurer denied me my hospitalization benefit for another high risk pregnancy, instead of their being a happy ending I suffered a tragedy that still haunts me today. My unborn baby of eight months died unnecessarily because I was denied proper medical care. I thought I had the same good health care coverage and therefore I thought I would get all of the proper medical care I needed as with the previous high risk pregnancy.

My story is not of a person being uninsured or underinsured. I had a good union-bargained health plan that supposedly provided coverage for all needed hospital, physician, and other medical care. But the end results were that a utilization review board, thousands of miles away from me, could make life threatening decisions about my care without ever seeing me.

This so called medical utilization board only had clerical staff - LPN's and RN's making medical decisions. They overruled my own doctor who was treating me day in and day out and has a medical degree.

My doctor determined that I had another high risk pregnancy and needed to be hospitalized as I was the prior year when I was monitored by the machines and nurses around the clock. During the previous pregnancy, I was in labor and delivery for two weeks being watched day in and day out in case the baby went into fetal distress. Two weeks into my second hospital stay my insurance plan informed my doctor and the hospital that they were cutting off my medical coverage due to the fact that they felt that I could get the same type of care at home that I was getting in the hospital. They over ruled my doctor's advice and orders and the only thing he could get for me was a home health nurse to come to my home a few hours a day to check on me. I only lasted at home two weeks before one night my baby went into fetal distress without me knowing. With no one monitoring me, my baby died while I was eight months pregnant.

You can't tell me that with the same high risk pregnancy back to back that the insurer the second time around decided it didn't want to have to spend the money it did the first time and so made an economic decision to deny me my needed hospitalization. The bottom line was dollars and cents not my well being and health care. I was forced out of the hospital and told my medical benefits were being cut off. I felt at that time I had no recourse because they always stated they had our best interest at heart.

Little did I know that under ERISA I really didn't have any recourse. My baby died because my supposedly good health plan denied me proper medical care. After taking my insurer to court and then appealing the decision in the Fifth Circuit Court of Appeals I learned that under ERISA the insurer could not be held accountable for my baby's death. And that ERISA preempted state law from applying to my case. In effect, the insurer got away with murder and will never be held accountable, but I have to live with the consequences for the rest of my life. ERISA, a law designed to protect people like me, instead protects insurers from being held liable in cases of wrongful death.

The Judges of the Fifth Circuit Court of Appeals stated they sympathized with me and that a grave mistake may have been made but that my only remedy was to get Congress to change the law.

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Lesson three: Health plans must be held accountable for their decisions. The Clinton Health Care Plan must not allow health alliances or health plans to make what amounts to economic decisions without having to pay the consequences for those decisions.

Lesson four: The Clinton Health Care Plan must provide fair claims procedures when health plans unfairly deny coverage and claims. No health plan should be able to get away with murder like my insurer has. Either there must be new remedies created under ERISA or under the Clinton Health Care Plan that allow people like me to sue in wrongful death cases or when coverage and care is denied.

Lesson five: Meaningful remedies must include more than the Ombudsman that the Clinton Plan is now talking about. People must be able to get quick decisions when life threatening situations arise. At the same time there should be penalties set in place when insurers deny appropriate medical care within a certain time frame. People should be able to go to court when insurers deny legitimate medical care and the insurers should be held accountable and have to pay punitive damages when they are truly negligent.

No amount of money is going to bring my baby back. But if the insurers had to pay punitive damages for their economic decisions in denying proper medical care they would think twice before making a life threatening mistake again. Currently, because insurers are not held accountable and do not have to answer to anyone, tragedies like mine have occurred and will continue to occur. Insurers should not be allowed to get off scott free without being accountable.

Again, thank you for allowing me to testify before this Subcommittee. I would be happy to answer any questions you might have.

Chairman WILLIAMS. Our next witness is Dr. Beth Buehlmann. It is nice to see you again. Usually we sit closer together up here.

STATEMENT OF BETH BUEHLMANN, ARLINGTON, VIRGINIA

Ms. BUEHLMANN. Thank you, Mr. Chairman. I welcome the opportunity to appear before you and other members of your committee today to tell my story, my son Eric's story, because it is one that raises a number of issues that I believe have to be considered in any health care reform package. Fortunately for me, this story has a happy ending.

Let me start by asking each of you what you were doing on January 20 of this year? In case the date doesn't ring a bell, it was inauguration day. For myself, I was looking forward to a quiet day away from the office with no outside distractions. Obviously, no invitation to the balls either.

Instead, I was at Georgetown University Hospital, praying that my 24-year-old, otherwise healthy, son would survive a massive brain hemorrhage that one doctor described in the following way: It is as though his head hit a brick wall going 60 miles per hour without the protection of a helmet, yet with no outside visible signs of damage. By noon, he had made it through the emergency craniotomy, but the prognosis was dismal.

It was less than a week before that Eric has been diagnosed with ITP, thrombocytopenic purpura, an idiopathic disease which causes the body to destroy its own platelets—the element of your blood which aids coagulation. He had been undergoing therapy for the ITP but had been told that he was not responding well to the steroids. A different, more invasive therapy would have to be started that Thursday, January 21. It was at this point that the doctor learned a disturbing fact—Eric did not have health insurance.

Although Eric was in his last semester of law school, because of a hold on his registration, he was not officially enrolled. As some of you may know, health care coverage for many students is enrollment driven. To add insult to injury, because Eric has technically been carrying less than a full-time course load in the fall semester, he had not been covered then either. This fact became important in determining whether he was covered by COBRA—obviously not.

Quite frankly, even if Eric had been covered by the student health insurance policy, it was only for $25,000. If he had done everything right, it still wouldn't have mattered because his initial hospital bills alone were close to $200,000. In order for him to have had greater coverage, he would have had to affirmatively request that coverage and pay an additional fee. Most students, as I found out later, were unaware of this option.

For any of you familiar with the life of a graduate student, you recognize that even the smallest cost would have been difficult to scrape together when you live on loans and other borrowed money, along with possible earnings from a part-time job. Besides, why would a healthy, young adult need more catastrophic coverage?

In the two days after his initial surgery, Eric required an emergency splenectomy and an angioplasty. Removing his spleen was the last resort the doctors had in trying to stabilize his platelet count. When Eric was admitted, his platelet count was 4,000. The average person's count is 300,000 to 400,000. If his platelet count

could not be raised, it was likely that he would have a second, probably fatal, head bleed. Each of these procedures was life threatening but, in the balance, necessary.

Throughout this period of stress and emotional upheaval, the question remained, how would all of this be paid? Medicaid? Declaring bankruptcy? Hospital charity programs? Assumption of my house, even though Eric did not live with me and had not been claimed as a dependent for years?

After consulting a few lawyers, two things remained unclear because Eric had lived in my house until the previous August, at which time he moved into the District of Columbia. The first was, if he qualified for medicaid, in which jurisdiction would he be covered? The second was whether my assets would be counted against Eric in determining his eligibility and whether they would be considered as a possible source of payment for his hospital costs. None of the lawyers was willing to assure me of the answer to either question, but I was told emphatically to sign no papers which had any possibility of creating a fiscal liability for me.

Medicaid only considers assets, not liabilities in determining eligibility. Therefore, his student loan debt had no bearing on his situation. DC said that Eric lived in the District only because he was a student. Therefore, he would not be considered eligible in DC and needed to apply for Virginia medicaid.

Because Eric no longer lived with me, Virginia medicaid said he was not their responsibility either. My decision finally was made on the basis of the medicaid that was more universally accepted at the hospital and on the basis of where he was living—DC.

It was more than three weeks after his brain hemorrhage before Eric qualified for DC medicaid. Only then was I somewhat assured that I would not be held liable for my son's medical bills. However, I want to make one thing clear. Regardless of the cost, I would have risked my financial future, if that is what it took, to make sure that Eric received the medical and rehabilitative care that he needed and continues to receive.

Based on my experience, I would like to make the following points:

College students are extremely vulnerable when it comes to health care coverage, which, in turn, places their families at risk as well;

The level and availability of health care coverage a person receives should not be decided on the basis of residence;

Family members should not have to worry about the fiscal liability they may face, when the focus of their efforts should be in support of the ill person;

Once a child is independent, parents' assets should not be placed at risk either by their proximity or involvement at the time of the crisis; and,

Artificial barriers to service should not exist because of arcane bureaucratic rules, regulations and insatiable documentation requirements.

It is now nine months after Eric's experience. He has overcome extraordinary odds and has made almost a complete recovery. Given the severity of the initial effects of the hemorrhage and the original prognosis, his only remaining residual effect is a signifi-

cant eyesight deficit. He is clearly the beneficiary of outstanding medical treatment and rehabilitative services. Without the efforts of the doctors, nurses and the therapists at Georgetown University Hospital and the National Rehabilitation Hospital who have worked with him, he could not have made it this far. In fact, his therapy is now focused on getting Eric back to law school part time in January, just one year after all this happened

As I stated in the beginning, this is a story with a happy ending. However, it could just as easily have been otherwise. We need to assure a means of funding catastrophic illnesses without bankrupting the individual, the family, the Nation and the system. I hope that with health care reform this goal can be achieved.

Thank you.

Chairman WILLIAMS. Thank you.

[The prepared statement of Ms. Buehlmann follows:]

STATEMENT OF MS. BETH B. BUEHLMANN

Mr. Chairman, I welcome the opportunity to appear before you today to tell my story, really my son Eric's story, because it is one that raises a number of issues that I believe have to be considered in any health care reform package. Fortunately for me, this story has a "happy" ending.

Let me start by asking each of you what you were doing on January 20 of this year? In case the date doesn't ring a bell, it was inauguration day. For myself, I was looking forward to a quiet day away from the office with no outside distractions, obviously no invitations to the balls either. Instead, I was at Georgetown University Hospital, praying that my 24-year-old, otherwise healthy son, would survive a massive brain hemorrhage that one doctor described in the following way: it's as though his head hit a brick wall going 60 miles per hour without the protection of a helmet, yet with no outside visible signs of damage. By noon, he made it through the emergency craniotomy, but the prognosis was dismal.

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In the two days after his initial surgery, Eric required an emergency splenectomy and an angioplasty. Removing his spleen was the last resort the doctors had in trying to stabilize his platelet count [when Eric was admitted, his platelet count was 4,000; the average person's count is 300,000 to 400,000]. If his platelet count could not be raised, it was likely that he would have a second, probably fatal, head bleed. Each of these procedures was life threatening, but in the balance, necessary.

Throughout this period of stress and emotional upheaval, the question remained, how would all of this be paid? Medicaid? Declaring bankruptcy? Hospital charity programs? Assumption of my house, even though Eric did not live with me, and had not been claimed as a dependent for years? After consulting a few lawyers, two things remained unclear because Eric had lived in my house until the previous Au-

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As I stated in the beginning, this is a story with a "happy" ending. However, it could just as easily have been otherwise. We need to assure a means of funding catastrophic illnesses, without bankrupting the individual, the family, the Nation, and the system. I hope that with health care reform, this goal can be achieved.

Chairman WILLIAMS. Our final witness is Miss Karin Allen.

STATEMENT OF KARIN ALLEN, BETHESDA, MARYLAND

Ms. ALLEN. Good morning, Mr. Chairman and members of the committee. It is an honor to be here today. Thank you for inviting me.

My name is Karin Allen. I am an employee of Floor Covering Resources, a small company in Kensington, Maryland. I am here today to describe the problems our small company has in getting health insurance.

I have worked for Floor Covering Resources since 1984 as a full-time employee. Until 1987, I was the only employee of this company. When we hired my co-worker, Mike, we finally qualified for small group health coverage. Our employer, Roger Flaherty, purchased a generous plan for us in Blue Cross Blue Shield that included family coverage for me and individual coverage for Mike.

My employer paid the full cost of the premium. In 1987, his cost to cover me was $167 a month. In 1988, the premiums increased 23 percent even though we had no major claims. Mr. Flaherty's cost to cover me jumped to $208 per month.

In October, 1988, I suddenly experienced severe pain in my neck and right arm. I was diagnosed with a herniated disk. I had back surgery in December of that year. I was out of work for two months and needed ongoing outpatient therapy. My health costs were over $19,000 that year, and I was glad that I didn't have to worry about major health expenses.

I was the only member of our group to file health insurance claims in 1988. When our policy was up for renewal in November 1989, the premiums of our group increased another 70 percent. In two years, our premiums increased a total of 130 percent. I filed a complaint with the Maryland Insurance Commissioner's office on behalf of Floor Covering Resources to contest this outrageous increase. Our insurer, Blue Cross and Blue Shield of the National Capital Area stated that our group was reclassified as a high-risk group rather than an average-risk group because our ratio of claims to premiums paid was too high. Since I was the only member of the group that year to file a claim, these increases are completely attributable to the cost of my back surgery.

My company is really stuck. With my preexisting condition, I might be ineligible for insurance if I went to another company. I continue to need treatment for my back problem. Last August, I had an epidural nerve block performed because of excruciating nerve pain. And our group premiums continues to rise. In November, 1993, the monthly premium to cover me, not a family policy, will increase to $640 per month.

I earn a little more than $18,000 per year. My employer will pay over $7,600 for my single health insurance coverage. That equals 42 percent of my salary. Mr. Flaherty was able to give me one raise in the time I have worked for him. Now I know that my raises are going to health insurance costs.

In some ways, I am lucky. My employer still covers the full cost of our insurance premiums, but he doesn't know how long he will be able to afford it. Since Mr. Flaherty is over 65, he is covered by medicare. He continues to provide us insurance out of generosity, not his own personal need, but soaring costs could make him reconsider.

As the administrator of our health insurance, I have done everything I can think of to bring these costs down for him. I have talked with a dozen different insurance companies, and they tell me our group is uninsurable because of preexisting conditions. These are large corporations like New York Life, Prudential and Cigna.

We still remain with the same insurance company, and we have the same insurance coverage. However, I really worry about the burden this cost places on my employer and whether he will be able to continue buying my coverage. I see my standard of living jeopardized because of these costs.

It is bad enough to have a chronic health problem. Worrying about health insurance only makes the situation worse.

Thank you very much for this opportunity. I will be happy to answer any questions you might have.

Chairman WILLIAMS. Thank you very much.

[The prepared statement of Ms. Allen follows:]

KARIN ALLEN

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than an "average risk group" -- because our ratio of claims to premiums paid was too high. Since I was the only member of the group to file a claim, these increases are completely attributable to the cost of my back surgery.

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As the administrator of our health insurance, I have done everything I can think of to bring these costs down. I have talked with a least a dozen different insurance companies, and they all tell me that our group is uninsurable because of pre-existing conditions. These are not little insurance companies, but large corporations like New York Life, Prudential and Cigna.

We remain with the same insurer and we have the same insurance coverage. However, I worry about the burden this cost places on my employer, and whether he'll be able to continue buying our coverage. I see my standard of living jeopardized because of these costs. It's bad enough to have a chronic health problem. But worrying about health insurance only makes the situation worse.

Thank you again for this opportunity. I am happy to answer any questions you might have.

Blue Cross
and
Blue Shield
of the National Capital Area

550 12th Street, S.W.
Washington, D.C. 20065
202/479-8000 Telex 140965 Cable BLUE
Chartered by the Congress of the United States

September 27, 1989

Mr. Sal P. Ercolano, Sr.
Acting Chief Investigator
Life and Health
Department of Licensing and Regulation
Insurance Division
501 St. Paul Place
Baltimore, Maryland 21202-2272

Dear Mr. Ercolano:

This is in response to your letter of September 7, 1989 regarding rate increases for Floor Covering Resources. Ms. Karin Allen has addressed our group rating practice for small groups. With that in mind, I have provided a description of our rating practices and alternatives available for Floor Covering Resources.

Floor Covering Resources is part of our 2-49 Community Rated Pool. The base rates are established by using the aggregate claims expense of the entire pool.

During the past two years, we also differentiated our rate increases in this pool by classifying those groups as either low, average or high risk groups. This was done to more equitably distribute the rate increases so that those small groups which used the least health benefits received a lower increase than those groups which used more health services.

The determination of risk category was made by comparing the paid claims of the prior calendar year with the premium generated during the same period. To safeguard against penalizing a group account for large individual claims, any participant claims in excess of $2,500 were discounted prior to the comparison of claims to premiums. A group where claims to premiums ratio is greater than 71% is considered a high risk group.

Floor Covering Resources was classified as an average risk group on their November, 1988 rate renewal. On the subsequent November, 1989 renewal, the 1988 incurred claims were $19,840. Of those claims, $15,064 were discounted because they were greater than $2,500. The health premium for the period was $4,206, a 84% claims to premium ratio which is classified as high risk.

Floor Covering Resources does have alternatives available to lower their health care costs. The group can retain their current benefits with our PPO Overlay Option and still reduce their rates as shown in the following illustration:

Age	Current Rates	Rates With PPO Overlay Option
29 and under	$181.74	$156.22
45-49	$379.96	$324.68

As you may notice, by retaining their current benefits with the PPO Overlay, Floor Covering Resources can realize an immediate savings of 14.38% over their new rates. Another option that is available for them to consider is our Standard Hospitalization and Major Medical with a $500 deductible and a $2,000 stoploss. The rates for that program would be $144.42 and $299.12 for both the individuals covered.

We at Blue Cross and Blue Shield of the National Capital Area share Ms. Allen's concerns about the escalating health care costs. Our rating method does provide a more equitable distribution with lower rates to lower utilizers of health care services. Conversely, groups with older/higher utilizers of claims receive higher than average premium rates. One of our Representatives will be in touch with Ms. Allen to discuss the various options that are available to Floor Covering Resources.

Thank you for the opportunity to respond to Ms. Allen's concerns. If you have any further questions, you can reach me at (202) 479-8800.

Sincerely,

George A. Brown
Vice President and General Manager
Consumer Accounts

re: Karin Allen
Group #A819

Blue Shield
of the National Capital Area

Rates as of Nov. 1, 1987

KARIN L ALLEN
FLOOR COVERING RESOURCES
4811-B BETHESDA AVE.
BETHESDA MD 20814

MMARY OF DETAILED ENROLLMENT ACTIVITY AND PARTICIPANTS THROUGH 03/31/88 FOR GROUP A8190000

DETACH DETACH DETACH

) NUMBER	NAME		SVC	COVERAGE RATE	DATE	AUTHORIZED ADDITIONS	AUTHORIZED DELETIONS	ADJUSTMENT RETRO/PRO-RATE
ROLLED PARTICIPANTS AS OF 02/01/88:								
7389745	ALLEN	KI	AHAA	✓ 168.92	11/01/87			
9861408	ALLEN	EM	1HAA	77.96	11/01/87			
0820061	BRANDLAND	MC	1HAA	77.96	11/01/87			
T AL				324.84				

RO ACT, ETC., MAY AFFECT YOUR PAYMENT. THEREFORE, PLEASE REMIT THE TOTAL AMOUNT DUE ON PAGE 1.

DATE PREPARED 02/02/88 FOR MARCH 1988 COVERAGE PAGE NO. 0002

CLAIMS DEFERRALS MAY RESULT IF CURRENT PAYMENT IS NOT RECEIVED BY THE DUE DATE.
CANCELLATIONS MAY RESULT IF PAST DUE PREMIUMS ARE NOT RECEIVED BY THE DUE DATE.

November 1988

GROUP NUMBER: AB19

MONTHLY RATES

AGE RANGE	SELF-ONLY	FAMILY
29 AND UNDER	$ 96.22	$ 224.50
30 - 34	120.28	269.40
35 - 39	144.32	314.30
40 - 44	176.40	426.56
45 - 49	208.48	538.80
50 - 54	256.58	606.16
55 - 59	304.68	695.96
60 - 64	360.82	808.20
65 AND OVER	441.00	987.80

COMPLEMENTARY TO MEDICARE: $131.64

November 1, 1989

Blue Cross and Blue Shield of the National Capital Area

GROUP NUMBER: A8190000

MONTHLY RATES

AGE RANGE	SELF-ONLY	FAMILY
29 AND UNDER	$ 181.74	$ 429.12
30 - 34	224.22	507.04
35 - 39	266.70	586.56
40 - 44	323.34	783.38
45 - 49	379.96	980.20
50 - 54	464.90	1098.28
55 - 59	549.86	1255.74
60 - 64	648.96	1452.56
65 AND OVER	790.54	1767.46
COMPOSITE RATES	280.85	0.00

COMPLEMENTARY TO MEDICARE: $174.66

RATES SUBJECT TO REVIEW IN SIX MONTHS

leCross BlueShield
the National Capital Area

10-4-93

KARIN L ALLEN
FLOOR COVERING RESOURCES
4212 HOWARD AVE
KENSINGTON MD 20895

MMARY OF DETAILED ENROLLMENT ACTIVITY AND PARTICIPANTS THROUGH 11/30/93 FOR GROUP A8190000

) NUMBER	NAME	SVC	COVERAGE RATE	DATE	AUTHORIZED ADDITIONS	AUTHORIZED DELETIONS	ADJUSTMENT RETRO/PRO-RATE
ROLLED PARTICIPANTS AS OF 10/01/93:							
73899745	ALLEN KI	AWAD	638.60	11/01/88			
20820061	BRANDLAND MC	1WAD	246.88	11/01/88			
O T A L			885.48				

ETRO ACT, ETC., MAY AFFECT YOUR PAYMENT. THEREFORE, PLEASE REMIT THE TOTAL AMOUNT DUE ON PAGE 1.

DATE PREPARED 10/04/93 FOR NOVEMBER 1993 COVERAGE PAGE NO. 0002

CLAIMS DEFERRALS MAY RESULT IF CURRENT PAYMENT IS NOT RECEIVED BY THE DUE DATE.
CANCELLATIONS MAY RESULT IF PAST DUE PREMIUMS ARE NOT RECEIVED BY THE DUE DATE.

RETAIN THIS PORTION FOR YOUR RECORDS

ELIGIBILITY: PLEASE REFER TO THE GROUP CONTRACT FOR ELIGIBILITY REQUIREMENTS.

EARLIEST DATE CREDIT CAN BE TAKEN: 08/01/93
FOR QUESTIONS ON THIS INVOICE CALL: 479-0841 DA

PRIOR AMT BILLED 09/01/93:	$786.40	
PAYMTS REC 09/13/93:	$786.40CR	
	BALANCE FORWARD:	$0.00

	CONTRACTS	AUTHORIZED	ADJUSTMENT
BEG AUTH:	2	$786.40	
RATE ADJ:		$786.40CR	
		$885.48	
END AUTH:	2	$885.48	$0.00

PAID OCT 11 1993
9471

TOTAL AMOUNT CURRENT INVOICE: $885.48

AMOUNT BILLED: $885.48

TOTAL AMOUNT DUE BY 10/21/93: $885.48

BLUE CROSS AND BLUE SHIELD
OF THE NATIONAL CAPITAL AREA
GROUP NUMBER: AB190000

10/04/93 NOVEMBER 93 0001 1
DATE PREPARED FOR COVERAGE PAGE NO.

CLAIMS DEFERRALS MAY RESULT IF CURRENT PAYMENT IS NOT RECEIVED BY THE DUE DATE.
CANCELLATIONS MAY RESULT IF PAST DUE PREMIUMS ARE NOT RECEIVED BY THE DUE DATE.

See Reverse Side RETAIN THIS PORTION FOR YOUR RECORDS

T A L			885.48				

RG ACT, ETC., MAY AFFECT YOUR PAYMENT. THEREFORE, PLEASE REMIT THE TOTAL AMOUNT DUE ON PAGE 1.
10/04/93 NOVEMBER 1993 0002
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Chairman WILLIAMS. Mrs Roukema.

Mrs. ROUKEMA. I don't know where to begin with the questions, because those of you who heard my opening statement may understand that I have great empathy for the subjects that you have addressed. The empathy I have is in the context of my statement that health care reform is not just about cost benefit analysis and how we are going to reduce the costs, it is also about maintaining quality of care, choice of care and expanding access to care. So I certainly am empathetic to what you have outlined here.

Ms. Corcoran, I came in on the middle of your testimony, but I will take it at face value that it is a problem of ERISA preemption in terms of the wrongful death. I won't go into the legal questions there, but I do acknowledge that when this subcommittee addressed the pilot life question I advised my own Republican colleagues to understand that preemption should not be applied in these kinds of cases where we are discussing the care, the continuum of care in specific cases.

I am with you, Ms. Corcoran. I don't know how we will resolve that issue, but I believe to that extent ERISA preemption is a dead issue in the context of health care reform, and I don't know how to resolve it with precision in the law, but I certainly agree with you.

The others—and I didn't hear Miss Slezak—but Dr. Buehlmann, we have discussed her son's situation although not in full—obviously, this is one of those areas where no matter what reform is adopted, whether it is the President's outlined proposal or whether it is some other form of managed competition or the Republican proposals, we obviously have to close those loopholes and those gaps.

I think what was captured most poignantly in the President's speech, although I don't believe his proposals specifically come to address the issue, but the driving force behind health care reform, no matter which way you come up with a conclusion, is the fact that most Americans live—and this is a quote from the President—most Americans live with the fear that they are one pink slip or one serious illness away from financial ruin.

The complication comes and the one that I haven't figured out, nor have we had specific testimony on from the administration or from the business and health insurance groups that are yet to come before us, is the profound problem that Ms. Allen points out. I am not asking a question here. I am making a statement. Because I want you to know that we have to follow up on the problems that you have outlined.

Ms. Allen has pointed out that even the good citizens in the business community are absolutely strapped because of the astronomical and exponential rise in health care costs. I can't account for those rises. I would like to have an explanation from the insurance companies as to why that cost increase is 120 percent in a two-year period. That is extraordinary.

I don't know how to account for it—unless it is a straightforward advance of picking up the uncompensated care costs not only for those that aren't insured but for the extraordinary problems of our society that come as a consequence of drugs and crime and AIDS and neonatal care for premature babies and on and on, the cost of

which society is paying for while the astronomical costs of our urban problems are rising out of sight. Our emergency rooms in our cities are MASH units, and we are paying for it.

I don't know what the answer is to those rises, but neither small business nor their employees can be expected to bear that burden alone any longer. Would you like to respond, please?

Ms. ALLEN. Yes, because I have the letter here that was written from Blue Cross Blue Shield to the Maryland State Insurance Commissioner which states in the fifth paragraph here that really my claim was the culprit for this rate increase and being reclassified as a high-risk group.

Mrs. ROUKEMA. I understand that.

Ms. ALLEN. I think our premiums might be less if I did not have this——

Mrs. ROUKEMA. It is the size of the increases. Obviously, we have to have pools that are large enough. But that is not the total answer, increasing the pools. I simply don't know how they document the size of the cost increases.

Only in recent years have we had that size cost increase for small business, so I want to know how their cost accountants would account for that. It is your illness, but I am sure it is because they are picking up a lot of costs with community rating, et cetera. Pooling is the answer but maybe not the total answer.

Thank you very much.

Chairman WILLIAMS. Mr. Hoekstra.

Mr. HOEKSTRA. I have no questions for the panel, but I very much appreciate the testimony that you have provided to us today. I think it points out the complexities of the issues, but perhaps more importantly, the human side of the problems that we are dealing with. So thank you very much for sharing your stories with us today.

Thank you.

Chairman WILLIAMS. I, too, want to add my thanks to each of you. I know that the testimony for each of you was not easy, and we are very appreciative of your willingness to be here because I think that the difficulties you have all experienced are experienced every day by hundreds, if not thousands, of people across this country. And whatever legislation we finally pass has to have that key element of security in it so that we can avoid as best as possible repetition of the difficulties that the four of you have experienced. Thank you very much for being with us.

Now if the two members of our final panel will come forward please, Dr. Helms and Mr. Galles.

STATEMENTS OF ROBERT HELMS, RESIDENT SCHOLAR AND DIRECTOR OF HEALTH POLICY STUDIES, AMERICAN ENTERPRISE INSTITUTE, WASHINGTON, DC; AND JOHN PAUL GALLES, EXECUTIVE VICE PRESIDENT, NATIONAL SMALL BUSINESS UNITED, WASHINGTON, DC

Chairman WILLIAMS. Mr. Richard Helms is the Director of Health Policy Studies at the American Enterprise Institute. Doctor, thank you for being with us. Please proceed.

Mr. HELMS. It is Robert Helms. I think Richard was with the CIA or something.

Chairman WILLIAMS. We apologize.

Mr. HELMS. Let me say that I direct health policy studies at AEI and have been dealing with this issue for about 20 years at AEI and at HHS. In that time I have dealt with a large body of academic researchers and others dealing with these issues, and they have generated a set of literature that would be helpful.

Somebody said there were two kinds of people, those that divide everything into two parts and those that don't. I have tried to identify two basic choices in terms of the policy debate. I call the first the intelligent American choice approach. Here I am trying to define what I think economists look at as a system based on incentives and competition where everybody has the right incentives to do the right thing and the result is better medical progress, better medical outcomes and taking care of the kinds of situations more efficiently that we just heard from the prior panel.

The second approach I would label the stockyard approach. This approach sets up barriers to herd American consumers and providers into designated stalls so they do not have the freedom to make their own choices about health care. To be effective, this approach requires a large investment in good fences which take the form of government-imposed rules and regulations that control expenditures, as in global budgets, and prices, as in fee schedules, and a system of rationing when shortages inevitable occur. With enough enforcement, this approach can control measured expenditures but at the sacrifice of consumer choice, quality of care and the rate of scientific medical innovation.

As you can tell from the way I have described these two choices, I am strongly in favor of the first approach.

Let me bring up what I think would be three topics from this literature that I think the committee should consider as it addresses the whole issue of health care reform.

The first is the concept of economic efficiency. The fundamental lesson of economics is that improving economic efficiency is not the same as reducing expenditures. In addition to combining inputs in the least-cost manner, the concept of economic efficiency puts great emphasis on producing the combination of goods and services desired by consumers. And, in an efficient market economy, producers have strong incentives to adopt new technologies, even when they may add to costs, if the new products are demanded by consumers.

Policies that concentrate only on reducing expenditures have at least two undesirable side effects. First, they deny consumers the opportunity to express their own preferences, and, second, the health providers may either be prevented or induced by constraints not to adopt cost reducing technologies even when they have a benefit.

Last week at an AEI forum I was taken to task by Walter Zelman, a Clinton health task force leader. He argued that it was not politically feasible to discuss the topic of changes in the tax policy of health insurance affecting health insurance.

Regardless of how you feel about this issue, I feel I have a duty to tell you about the role that tax policy has played in creating the distorted set of incentives we have and about the critical role a change in tax policy must play if you want to avoid government

regulation and establish a health care system that improves economic efficiency.

This topic has been written about by scholars for 20 years. It basically argues that people—by taking away, distorting the incentives between wages and health insurance, people have an incentive to get more and more insurance. And it has gradually over the years changed the form of insurance and helped feed into the payment problem where people look at what somebody else is paying for their care.

In no way do I think that people who propose a change in the tax treatment of health insurance necessarily want to do it as a way to increase taxes on business or individuals. I would be happy for the Congress if you did this to take away the distorting influence of this and to also reduce the business and personal tax rates so that there is no net increase in Federal revenues. Of course, the issue of political feasibility raises its head again, so my fear is that if the Congress will not face up to the distorting effects of tax policy, then Federal and State health policies will continues to move toward the stockyard approach of increasing regulation and controls. Like most stockyards, government regulation has a certain messy component associated with it.

Let me look at this large literature, much of which was developed in the 1970s, about the effects of government regulation. I think this is also—should be helpful to the committee. I have put a lot of references in my written testimony to this literature.

One thing that is predicted is that the process of allocating the targets proposed by the administration will become political. I see no reason that the National Health Board or the boards of the many regional health alliances would be immune to the known tendency of public utility commissions to become embroiled in issues of fairness and procedure and have no economic effect on their regulated industries. At most, this complicated scheme will create a great amount of sound and fury and waste a lot of money on administrative costs but will have little real effect on health expenditures. In my written testimony I go through reasons why I think that would happen.

My arguments in favor of a competitive approach to health reform should not be taken as a defense of the status quo or of any particular health proposal. I do believe that the present system needs reform to correct some of the distorted incentives we have created in our current system and that we heard about this morning, but we should be careful not to destroy the positive changes that are now occurring, especially in the provision and design of employee health benefits. My plea is that we do our homework and utilize the research and analysis of the last 20 years to create efficient medical markets that rely on competitive medical progress and to satisfy consumers. We should avoid the temptation to walk off into the quagmire of government price and expenditure controls.

Thank you, Mr. Chairman.

Chairman WILLIAMS. Thank you.

[The prepared statement of Mr. Helms follows:]

Testimony of
Robert B. Helms
October 21, 1993

Having grappled with the health reform issue for approximately 20 years in my positions at the American Enterprise Institute and at HHS, I have identified and worked with a large number of health policy experts who have been doing research about the performance of the health care sector. I believe this body of research can help this subcommittee and the Congress identify the root causes of our current problems and the basic choices we have to solve these problems.

I intend to present my own interpretation of this research in the hopes that it will help the subcommittee identify the consequences of no legislative action on health reform or of any particular reform plan such as the Clinton Administration's American Health Security Act. It is not my intention to advise Members of Congress on the "political feasibility" of any policy. I believe it is the professional responsibility of the policy research community to analyze the consequences of various policies so that policy makers can make better choices about what is best for the American people.

Two Basic Choices

The more-than-50-year debate about American health policy has swirled around two basic policy choices which can be described as follows:

1. **The Intelligent American Choice Approach.** This approach attempts to achieve an efficient health care sector by giving consumers and providers strong incentives to make intelligent and cost-effective choices about the use of limited medical resources. Providers of all kinds compete on the basis of

price and quality and are rewarded or penalized by changes in income for efficiently using the best of medical science to provide the kind of medical care desired by consumers. Consumers are rewarded by better medical outcomes and lower costs because of strong incentives to make careful and cost-effective choices.

2. **The Stock Yard Approach.** This approach sets up barriers to herd American consumers and providers into designated stalls so they do not have the freedom to make their own choices about health care. To be effective, this approach requires a large investment in good fences which take the form of government-imposed rules and regulations that control expenditures (as in global budgets) and prices (as in fee schedules) and a system of rationing when shortages inevitably occur. With enough enforcement, this approach can control measured expenditures, but at the sacrifice of consumer choice, quality of care, and the rate of scientific medical innovation.

As you can tell by the way I describe these two choices, I am a strongly in favor of the first approach. I believe we can achieve more efficient medical markets by changing individual incentives, but to do so we must face up to the distorting forces in present government policies. My fear is that we are on a pell-mell course to adopt a more regulatory approach to health policy. In my view, this will occur at the state level even if there is no federal legislation. As Derrick Max and I stated in *Roll Call* this week, this is because states cannot avoid the distorting effects of federal tax policy and therefore have very

limited options to adopt a market reform approach.[1]

The Economics of Health Care

As background for what is likely to be a year-long debate, I would like to review several basic economic topics that I think provide important guidance about how to reform our health care system. A guide to articles and studies that treat these topics in more depth are provided in the references.

The Concept of Economic Efficiency. All proponents of health policy reform, regardless of their philosophical approach, talk of their desire to improve the efficiency of our present system. A fundamental lesson of economics is that improving economic efficiency is not the same as reducing expenditures.[2] In addition to combining inputs in the least cost manner, the concept of economic efficiency puts great emphasis on producing the combination of goods and services desired by consumers. In an efficient market economy, producers have strong incentives to adopt new technologies, even when they may add to costs, if the new products are demanded by consumers.

Policies that concentrate only on reducing expenditures have at least two undesirable side effects. First, consumers that desire to purchase more health care products and services

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[1]Derrick Max and Robert Helms, "The States Have Failed on Health Reform After Encroachment of Federal Policies," *Roll Call*, October 18, 1993, p. 16.

[2]"An efficient system does not necessarily have the lowest costs. The most cost-constraining system is the one that incurs no costs. This obviously is not desirable." Mark Pauly, Patricia Danzon, Paul Feldstein, and John Hoff, *Responsible National Health Insurance* (Washington, D.C.: AEI Press, 1992), p. 3. See Chapter 2, pp. 3-4, for their discussion of the meaning of efficiency and equity.

may be denied the opportunity to express their preferences in the market. Second, while producers may still have an economic incentives to adopt new cost-reducing technologies, they may either be prevented or induced by regulatory constraints not to adopt cost-increasing new technologies. This prevents the adoption of new technologies even when they promise substantial net benefits to consumers.[3]

The Role of Tax Policy. Last week at an AEI forum I was taken to task by Walter Zelman, a Clinton health task force leader, for calling for a change in the tax treatment of health insurance. He argued, correctly in my view, that such a change was strongly opposed by both Democratic and Republican Members of Congress. He argued that it was not "politically feasible" to discuss this topic.

Regardless of how you feel about this issue, I feel I have a duty to tell you about the role that tax policy has played in creating the distorted set of incentives we now have and about the critical role a change in tax policy must play if you want to avoid government regulation and establish a health care system that improves economic efficiency.

Economists and other health policy analysts have been writing about the distorting effects of federal tax policies for over 20 years.[4] Beginning in World War II as a way to

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[3]Members of Congress who are part of the baby boom generation, or that represent large numbers of baby boomers, should keep in mind that many new medical technologies may take 20 years to complete scientific development and safety testing and be made available to consumers. Demographic projections indicate relatively large increases in the number of aged after the year 2012 as the increased number of Americans born after World War II begin to turn 65. A single-minded emphasis on cost-containment, rather than economic efficiency, could reduce the supply of new medical technologies in the future. What appears to be politically popular today could impose a future cost on a growing proportion of the American population.

[4]To sample some of this literature, see Martin S. Feldstein, "The Welfare Loss of Excess Health Insurance, " *Journal of Political Economy*, vol. 81 (March 1973), pp. 251-80; Ronald

compete for scarce labor under wage controls, health insurance began being provided by employers, and has never been treated as taxable income by the IRS. While this 50 year old policy has been credited with preventing the nationalization of health insurance that we have seen in other countries, it has also been identified as a major cause of "overinsurance" and "too much insurance of the wrong kind." By distorting the choice between taxable wages and non-taxable health insurance, this tax treatment of health insurance has caused the absolute growth of insurance, the gradual reduction of cost sharing, and the extension of coverage to types of medical care such as dental and vision care that are rarely associated with low-probability and expensive medical events. These large and long-term subsidies have gradually changed health insurance from the traditional concept of insurance (coverage of large and unexpected events) to a form of medical prepayment.

Because this tax preference is limited to employer-provided insurance, it has contributed to "the third-party payment problem" where each individual assumes that someone else will pay for whatever medical care they consume. Under such a system, there is little reward for choosing a hospital, physician, or medical procedure or product that costs

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J. Vogel, "The Tax Treatment of Health Insurance Premiums as a Cause of Overinsurance," in Mark V. Pauly, ed., *National Health Insurance, What Now? What Later? What Never?* (Washington, D.C.: American Enterprise Institute, 1980), pp. 220-249; Jack A. Meyer, "Health Care Competition: Are Tax Incentives Enough?" in Mancur Olson, ed., *A New Approach to the Economics of Health Care* (Washington, D.C.: American Enterprise Institute, 1981), pp. 424-449; Pauly, Danzon, Feldstein, and Hoff, *Responsible National Health Insurance* (Washington, D.C.: AEI Press, 1992); Eugene Steuerle, "The Search for Adaptable Health Policy Through Financed-Based Reform" in Robert B. Helms, *American Health Policy: Critical Issues for Reform* (Washington, D.C.: AEI Press, 1993), pp. 334-361; Alain C. Enthoven, "Why Managed Care Has Failed to Contain Health Costs," *Health Affairs*, Vol. 12, No. 3 (Fall 1993), pp. 36-37.

a little less.[5] This has led numerous analysts to identify the tax treatment of health insurance as a major cause of the rapid rate of growth of both health care prices and expenditures.

The distorting effects of the present tax treatment of health insurance have led almost all academic-based health reform proposals (except the single-payer proposals) to propose to either eliminate or limit the amount of the tax exclusion for health insurance.[6] In my view, making such a change in tax policy is almost a necessary condition for achieving economically efficient reform. It is the only policy change talked about which would affect the demand side of the market by giving individuals a greater incentive to be cost-effective purchasers of health care. This change in consumer behavior is essential to make competitive markets function as they should. If consumers demand more cost effective care

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[5]The distorting effects of federal tax policy have been exacerbated by the growing importance of state income taxes where employer-provided health insurance is not considered part of state taxable income. But since state income taxes rarely add more than 5 to 7 percentage points to federal marginal tax rates of 30 to 40 percent, the state effect remains relatively small when compared to the effect of federal tax policy. For recent estimates of the loss of tax revenue from different sources, see Stuart Butler *A Policy Maker's Guide to the Health Care Crisis, Part II* (Washington, DC: The Heritage Foundation, March 5, 1992) Table 12, p. 20.

These distorting effects are further exacerbated by the open-ended nature of Medicare and Medicaid which also gives little incentive for individuals to be cost-effective medical consumers. See Steuerle, "The Search for Adaptable Health Policy Through Financed-Based Reform" in Robert B. Helms, *American Health Policy: Critical Issues for Reform* (Washington, D.C.: AEI Press, 1993), pp. 334-361.

[6]A tax exclusion cap which limits the amount of employer-provided health insurance an individual can exclude from taxable income should not be confused with a tax deduction cap (as proposed in the Managed Competition Act of 1993, introduced by Reps. Jim Cooper and Fred Grandy) which limits the amount a business firm can deduct for the expense of providing health insurance to employees. Among other effects, these two types of tax caps could have substantially different effects on labor-management relations. It is my opinion that the former could create a mutual interest among labor and management in effective cost containment while the latter would tend to drive a wedge between the interests of labor and management.

(which may include even higher quality and service), then providers of all types will have no choice but to change their practices and compete more on the basis of price and quality.

Let me also say that calling for a change in the open-ended nature of the tax treatment of employer-provided health insurance is not an argument for increasing federal tax revenues or in any way "increasing the taxes on businesses or labor." This is an argument about eliminating the distorting effects of these tax policies, not an argument about increasing the level of taxes. If the Congress did not want to divert the expected increase in revenue to pay for expanded coverage of the uninsured (as proposed in several health reform proposals), it could lower both business and personal tax rates to assure no increase in federal revenues.[7]

My major disappointment with the Clinton plan is that they walked away from the changes in tax policy contained in the Jackson Hole Proposal that was the basis for much of their plan. As I read the September version of their plan (p. 239), they have established a procedure for firms with health benefits greater than contained in their standard benefit package to exempt this coverage for a period of 10 years. While extra benefits paid by the employer will be taxable to the employee after 10 years, this will have a small effect when compared with the numerous restrictions placed on regional and corporate alliances in the first 238 pages. They have clearly opted for the "stockyard policy" approach.

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[7]While this could be done in a revenue-neutral way, it would not be possible or desirable to avoid the differential effects on individual businesses and individuals. While the net effect on any one business or individual would depend on their level of benefits and marginal tax rate, it is likely that such a policy would create incentives for firms and individuals with extensive health insurance benefits to cut back and for firms and individuals with little or no benefits to obtain more coverage. While this would not assure universal coverage, it would increase the level of health insurance coverage without the net job losses that are likely to result from the Clinton Plan's employer mandates and small firm subsidies.

But the issue of "political feasibility" raises its head again. My fear is that if the Congress will not face up to the distorting effects of tax policy, then federal and state health policies will continue to move toward the stock yard approach of increasing regulation and controls. But like most stock yards, government regulation has a certain messy component associated with it. Substantial academic research and analysis indicates that the process of direct controls is more of a political and economic quagmire than a solution to our health policy problems.

The Economics of Government Regulation and Controls. During the 1970s this country lived through a brief period of wage and price controls and a continuing series of crises in several regulated industries such as transportation, public utilities, and natural gas. In response to this interest in regulation, the academic community produced a series of studies into the economic and political effects of wage and price controls and other forms of economic regulation.[8] In the health sector, several studies were done on the effects of hospital Certificate of Need regulations[9] and the probable effects of public utility and other

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[8]On the history of wage and price controls, see Robert L. Schoettinger and Eamon F. Butler, *Forty Centuries of Wage and Price Controls* (Washington, DC: Heritage Foundation, 1979). For an excellent review of the economics of government regulation, see Paul L. Joskow and Roger C. Noll, "Regulation in Theory and Practice: An Overview," in Gary Fromm, ed., *Studies in Public Regulation* (Cambridge, MA: The MIT Press, 1981), pp. 1-65.

[9]C. Havighurst, *Regulating Health Facilities Construction*, (Washington, DC: AEI Press) 1974; D.S. Salkever and T.W. Bice, *Hospital Certificate-of-Need Controls: Impact on Investment, Costs, and Use* (Washington, DC: AEI Press) 1979; F.H. Sloan and B. Steinwald "Effects of Regulation on Hospital Cost and Input Use" The Annual Meeting of the American Economic Association, Chicago, IL, August 29, 1978, p.37.

forms of regulation in controlling the rising cost of health care.[10] Much of this literature has not been updated because the Reagan/Bush Administrations, for the most part, turned away from the use of direct controls and the researchers went on to other issues. In response to the new attention to global budgeting, price controls, and insurance premium controls by the Clinton Administration, there has been a revival of this type of analysis.[11]

Based on this literature, it is my view that the optimism expressed by the Clinton Administration about the effectiveness of their global budgeting strategy is entirely unwarranted. It is unlikely to control health care spending and is highly likely to decrease the quality of service provided to consumers.

The first possibility is that the elaborate system of setting national targets for expenditures and allocating them to the states and to health alliances will simply not be done in a way that has any major effect on expenditures. In a changing health care market where there is beginning to be evidence that rates of increase in both medical prices and health expenditures are beginning to decline, it will be difficult to tell if the targets actually have an effect. One thing that can be predicted is that the process of setting and allocating the targets

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[10]For two survey articles of the health regulation literature, see Roger Noll, "The Consequences of Public Utility Regulation of Hospitals" in *Controls on Health Care* (Washington, DC: Institute of Medicine, National Academy of Sciences) 1975; and Robert B. Helms, "The Health Cost Problem: Is Regulation Our Only Hope?" *Bull. New York Academy of Medicine*, January-February 1980. In addition, thoughtful analyses of health regulation are contained in the articles by Crandall, Frech, Pauly, and Zeckhauser and Zook, White, and Starr in Part One of Mancur Olson, *A New Approach to the Economics of Health Care* (Washington, D.C.: American Enterprise Institute, 1981), pp. 29-128.

[11]See the articles by Stuart Butler, Charles Stalon, Henry Butler, Friedman and Coffee, and Danzon in, Robert B. Helms, ed., *Health Policy Reform: Competition and Controls* (Washington, D.C.: AEI Press, 1993), forthcoming (These papers were presented in an April 1993 AEI conference and are available from AEI).

will become very political.[12] I see no reason that either the National Health Board or the boards of the many regional health alliances would be immune to the known tendency of public utility commissions to become embroiled in issues of fairness and procedure and have no real economic effect on their regulated industries.[13] If a health alliance tried to be aggressive and set a limit on spending that is actually binding, then they would have the unpleasant experience of being the target of criticism by consumers, employers, providers, local politicians, as well as Members of Congress. It will be impossible to expand benefits and institute real reductions in per capita health expenditures. I fail to see the reward for any politician or health board member to take a tough stand on setting binding expenditure targets. At most, this complicated scheme will create a great amount of sound and fury and waste a lot of money on administrative costs, but will have little real effect on health expenditures.

Another problem is with the incentives for health plans to compete on the basis of price. The Jackson Hole plan envisioned a system where the health alliance ran a purchasing cooperative for employers. In that model, health plans had an incentive to be the lowest cost plan since the standard for the tax exclusion was based on the lowest cost bid for coverage of the basic package.

The Clinton plan drops the tax exclusion as a motivating factor and bases the standard for the employer mandate on the average cost of the approved plans and prevents the

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[12]If anyone doubts this statement, I would ask them to look at the evolution of congressional involvement in the setting of the annual DRG update factors and the redrawing of numerous urban/rural boundaries to increase the payments to specific hospitals.

[13]See especially the above mentioned articles by Charles Stalon and Henry Butler.

approval of any plan more than 20 percent above the average. While a plan that wants to expand enrollment might have some incentive to bid below the average, it would seem that this scheme would give each plan a strong incentive to make sure it bids a per capita premium close to the expected average. Such bidding schemes have a long history of collusion among sellers to the government.[14] Even if a health alliance can avoid explicit collusion, it is not at all obvious how they would avoid the implicit collusion when plans have strong incentives to bid near the average. Such a scheme puts little pressure on plans to control costs, rewards the status quo, and takes away the incentive for a competitive plan to be truly innovative in thinking up new ways to improve the quality of care and standard of service for consumers.

On the other hand, what does economic theory and the history of regulation predict would happen if the National Health Board did figure out a way to put binding limits on the budgets of health alliances? The result would be shortages and non-price rationing. This situation of "excess demand" is caused by consumers demanding larger amounts of services at the controlled prices and providers deciding to reduce their level of services in response to the controlled amount of revenue they will be allowed to receive. The queues and increases in waiting times that get so much publicity in Canada and European countries are only one of the many ways that providers have of reducing the level of service. Such a scheme takes away the incentive for the plan to be truly innovative in figuring out new ways to improve the quality of care and provide service and convenience to consumers. You would not get

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[14]See Armen A. Alchian and William R. Allen, *Exchange and Production: Theory in Use* (Belmont, California: Wadsworth Publishing Co., 1969), p. 405.

the intensity of competition on price and quality that was the central core of the Jackson Hole Proposal.[15]

Conclusion

My arguments in favor of a competitive approach to health reform should not be taken as a defense of the status quo or of any particular health proposal. I do believe that the present system needs reform to correct some of the distorted incentives we have created in our current system. But we should be careful not to destroy the positive changes that are now occurring, especially in the provision and design of employee health benefits.[16] My plea is that we do our homework and utilize the research and analysis of the last 20 years to create efficient medical markets which rely on competitive market incentives to make medical progress and to satisfy consumers. We should avoid the temptation to walk off into the quagmire of government price and expenditure controls.

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[15]Paul Ellwood, "Clinton Forgets His Health Care Allies," *The Wall Street Journal*, August 10, 1993.

[16]Note the similar caution contained in, Alain Enthoven and Sara Singerin in "Health Care is Healing Itself: Price Controls Won't Work," *New York Times*, August 17, 1993, p. A17.

Chairman WILLIAMS. Mr. John Galles is Executive Vice President of National Small Business United. Thank you for being here.

Mr. GALLES. Thank you for focusing on this important issue even though we have yet to see the specifics of the plan. I ask that you simply put my testimony into your record.

I would like to focus on the Clinton administration plan. National Small Business United believes that the current system forces small businesses to lose good employees if they cannot acquire good insurance. It forces small businesses to choose between paying good wages or affording escalating health premiums, and it forces many small business owners to be in a constant quandary between economic and moral over the benefits they provide their employees. So I think we can agree that the status quo must go. The question, of course, is what should replace it.

The Clinton administration has proposed a plan designed to address many of the problems that are raised in my testimony as well as many others. Though we have many specific comments on the plan, I would like to focus my comments on two, the impact of the mandate on small businesses, including the small business subsidy and payroll-based premiums, and the system of health care alliances that the plan would establish to deal with small business purchase of health coverage and the need for competitive purchasing cooperatives.

But before I take that step I would like to give you a picture of what we recommend. National Small Business United does have a plan for health care reform and for ensuring that all employees of small businesses and indeed all Americans have health coverage. We have been consistent with this proposal for over three years, well before many people have reached this conclusion.

We have recommended, number one, that we require everyone to have coverage; number two, that we reform the insurance system so that no one can be denied coverage; and, three, that we institute a system of Federal payments based upon family income so that everyone can afford coverage. It is a plan that responds to people, not to businesses; that responds to health care needs, not to employment status.

It is worth noting that NSBU agrees with the principles that President Clinton outlined in his plan. We think our own proposal encompasses all those principles and in some ways makes them even more simplistic and provides more security.

It seems to us that we have three distinct financing options for universal coverage. One would be for the government to cover everybody, the second is to require employers to cover all their employees and dependents with the government picking up the rest, and the third is to require all individuals to have coverage, with the government subsidizing those who need it.

We have rejected the government-run option on philosophical and substantive grounds. In addition, it is our perception that such a system stands little chance of adoption.

Between the two remaining systems we believe the individually-based system makes far more sense for businesses, for individuals, for providers and for the Nation. Unfortunately, the Clinton administration has chosen the employer-based premium. The employer-based mandate is essentially a payroll tax, but the Clinton plan

makes that connection explicit by gearing premium levels to payroll levels for small employers.

There are no more damaging taxes for small businesses and their employees than payroll taxes. In fact, we completed a survey where 81 percent of the small business owners said that an increase in payroll taxes would have a major negative impact on their businesses. They ranked it as the worst thing that could be done to finance the health care system.

I think it is important to recognize that our economy is dynamic, that there are businesses starting and failing every day. There are jobs created and jobs lost every day, but we need to have a net gain in the number of jobs in order to reduce our unemployment levels and see our economy expand. We don't want to be screamers in this debate, but we do think the impact of the payroll premium is substantially negative and encourages more layoffs during economic downturns and fewer jobs created as the economy recovers until people are more confident that there is a recovery there to support increased jobs.

With regard to the small business subsidy, I don't know of any small business that has ever asked for a subsidy for health care. I think most small businesses provide health care within their own means and their own capacity, and they work out different combinations of support for those health care plans between them as employers and their employees.

We are concerned about the system of subsidies, number one, because we know they are going to go away, we are not sure how quickly, but that 15 cents an hour is a number that is going to climb dramatically over time as we find a need to finance the benefits that are delivered within the packages. We think the system is entirely too complex, and it generally will lead to more people being system dependent, people who may choose not to work as a result of receiving health care and fewer people working to support the kind of payroll system that pays for this health care.

We do think that any subsidies that are developed within the plan could be substantially less expensive if they were focused on individuals and not on the employers.

We have also focused in our testimony on health care alliances. We are extremely concerned about singular, exclusive monopolistic health care alliances. While we understand that they will become the gorilla in the provider communities and they will be able to have an impact on costs within a community, we are concerned that after a while, in the longer term, those entities will have less to do with keeping financing down and become more responsible for financing the new system we are putting in place.

We do think that there is an incredible opportunity for you to encourage multiple competing purchasing cooperatives, albeit in the right way, certain regulations that would support cooperatives of certain sizes, a certain percentage within provider communities. We want them to do a much better job than METs and MEWAs have done in the past. We recognize that those have been insufficient and, in many ways, have been other attempts at cherry-picking within the system.

But we do think that you have to look at the term health alliance and how it was revised. Last spring we heard that they were called

HIPCs, and then the administration changed the name to alliance. When it became alliance it took on a much greater role and responsibility in health care reform.

We think the functions within the alliance of cost containment, of marketing cost reduction and administrative cost reduction are substantial tasks for that one entity. We think that privately organized, competing purchasing cooperatives can work on the administrative and the marketing cost containment and then you can raise up small business owners within those cooperatives to become partners with other payers of health care in an alliance to contain costs.

I was in Minnesota recently where there were 12 rural communities that came together to develop an integrated service delivery network, and they have, in fact, tried to combine the delivery of care in a way to reduce the cost. But, unfortunately, in that 12-county area there were eight counties that had county-owned hospitals, with an average daily occupancy rate of 35 percent. That integrated service delivery network didn't have the clout within that 12-county area to work on those counties to reorganize the way their hospitals were built and financed and managed. What they needed was a payor community, a purchaser-driven participation in this relationship.

And we are concerned with the alliances as they are designed in the Clinton plan, that they are simply dismissing the purchasers, taking them further away from the health care transaction and reducing their capacity to focus on health care cost containment in the community.

Let me end with that because I think we are going well beyond the time and you may have some questions.

Chairman WILLIAMS. Thank you.

[The prepared statement of Mr. Galles follows:]

John Galles

Mr. Chairman:

My name is John Paul Galles, and I am Executive Vice President of National Small Business United, based here in Washington, D.C. We very much appreciate the opportunity to be here.

National Small Business United (NSBU) represents over 65,000 small businesses in all fifty states. Our association works with elected and administrative officials in Washington to improve the economic climate for small business growth and expansion. We have always worked on a bi-partisan and pro-active basis. In addition to individual small business owners, the membership of our association includes local, state, and regional small business associations across the country. For the last four years, health care reform has been our top federal priority.

This hearing has been called primarily to ascertain the economic impact of health care cost increases on individuals, families, and business. In this regard, we could not agree more with the Clinton Administration: the current system is unacceptable and must be reformed.

In a survey conducted this past summer by NSBU and the Arthur Andersen Enterprise Group, forty percent of small business owners ranked health care benefits as the greatest threat to the future growth and survival of their businesses, more than taxes or regulations or the lack of available credit. Health care is the greatest policy concern of small businesses. Our survey showed that 67 percent of small businesses faced double-digit premium increases in the past year, with the *average* increase at 22 percent.

I. PROBLEMS WITH THE CURRENT SYSTEM

A. Health Care Costs

Employers of all kinds and sizes are finding it increasingly difficult to finance the cost of the health care of their employees. It is appropriate, then, that the health care debate in this country does not center around whether we are spending enough on health care; surely our spending outstrips any real necessity. The U.S. spends more per capita on health care than any other country in the world--more than double what Japan spends and 40% more than Canada, which is the second most expensive country. Twenty five years ago, health care consumed 5.9% of the GNP; in 1992, that number topped 14%, for a total of $840 billion. At this rate, we will see annual health care spending easily top $1 trillion by 1994.

Individual Responsibility

Why is it possible for these costs to continue to escalate in this way? Because there are currently very few checks within the system to counter these hikes. Most Americans have very low deductibles and co-payments and have very few personal incentives to check cost increases. And, insurance companies--except to some degree where there is a managed care program--have no way to control expenditures and physician and patient choices, so their high costs are simply passed on in the form of higher premiums.

In a sense, then, we have high health care costs largely because so many people never actually face any meaningful part of their health care bill. The combination of federal tax incentives and state mandates serves to encourage insurance-based financing of a broad range

of benefits at fairly low levels of deductibles. This arrangement keeps patients insulated and prevents them from behaving like normal consumers, who would otherwise seek a lower price for the same level of care. In order to be serious about cost containment, we must seek to inject a greater degree of consumer responsibility and sensitivity into the health care market.

There are also other reasons that health care costs continue to rise. For example, malpractice costs continue to escalate and must be dealt with. Hospital capital expenditures continue to soar; these costs must be reduced because many of the purchases are unnecessary. Medical advances continue to make more procedures possible, thereby increasing aggregate health care cost. Finally, the high technology of these medical advances is very expensive in its own terms. Clearly, there are good solutions to some of these cost problems, but not to all of them.

Cost Shifting

But there are additional reasons for cost increases on the private sector, other than the aggregate cost of health care. There are three major groups who finance the costs of health care in this country: 1) the government, 2) self-insured companies--generally big corporations, and 3) businesses which insure through traditional insurance companies--generally small businesses. Together with individuals, these groups finance virtually all of the nation's health care spending. It is important to realize that, to the extent that one of these groups pays less, the others pay more.

The federal government has a system which has had success in reducing the government's expenses for Medicare; it is a system which sets the amounts Medicare is willing to pay for particular services. However, it has done nothing to lower the overall costs of health care and

has actually driven up costs for the privately insured. When providers cannot get adequate compensation from the government, they simply raise the prices charged to everyone else. Large, self-insured plans frequently have a great deal of clout in a given area and can negotiate with providers in order to reduce the impact of this "cost shift" on themselves. However, small employers have no ability to reduce this cost-shift and must bear its full brunt. This same cost-shifting scenario also holds true for providers' expenses in delivering uncompensated care, primarily to the uninsured. For these reasons, no part of the business community is hit harder by the high costs of the uninsured than small business.

B. Small Business Problems

However, the health care cost problems of small employers cannot simply be dealt with at the macro level. There are unique equity problems faced by small businesses in financing the care of their employees, which go to the heart of how health care should be paid for—whatever its cost happens to be. These issues revolve around how small employers find and maintain adequate insurance coverage for their employees.

The insurance market for small employers is based upon individual underwriting. All employees--and each of their dependents--of a small firm are screened for past and present health conditions before any coverage is issued. If individuals in these groups have conditions, those conditions are routinely excluded from coverage. At the very least, dramatically higher rates are charged for these employees (and to some extent, all employees). Moreover, small employers with sick employees are frequently turned down for coverage altogether. When an employee gets sick while a given policy is already in effect, renewal time often finds the employer faced with premium increases which make the plan unsustainable. When this employer

shops for a new plan, other insurance companies either will not provide coverage or they will exclude from coverage the condition of the sick employee. These employers are often faced with the Hobson's choice of discontinuing coverage for a given individual in order to find coverage for everyone else.

To compound the problem, study after study has shown that even small businesses that can find and keep health insurance on average pay sharply more for that coverage than do big businesses. Therefore, the problem is not simply that all insurance--even that of large corporations--is too expensive (though it is); the problem is that small, marginal companies actually get a substantial and discriminatory price hike.

The insurance industry argues that the major reasons for this disparity are the high acquisition and administrative costs for small firms, combined with their relatively low renewal rates. Insurers' marketing costs are higher and must be continuous because their book of small firm business is constantly revolving. One of the major reasons for higher-than-average premiums for small businesses is that they are always switching insurance companies (called "churning"). Why is this churning so prevalent?

A major reason that small businesses switch insurance companies so frequently is that their premiums are frequently increased substantially after the first year of coverage. One of the major reasons these hikes occur is because pre-existing condition exclusions often expire after the first 12-18 months of coverage. The resulting premium increases often push small companies into switching plans, which serves to both further escalate administrative costs and to perpetuate the under-insurance of their employees--because they suffer a new round of pre-existing condition exclusions. Also, the competitive pressures on insurance companies may

encourage them to price a product at levels that are not sustainable past the first year. Premiums may also increase if new employee conditions have become present.

We must move back toward an insurance system that groups individuals in order to spread the risk of an individually large loss across a larger group. As it stands now for many small employers, insurance is merely financing their real costs and billing them back to the business, rather than spreading risk across larger populations.

II. SOLUTIONS FOR THE FUTURE

The current system forces small businesses to lose good employees if they cannot acquire adequate insurance; it forces small businesses to choose between paying good wages or affording escalating health premiums; and it forces many small business owners to be in a constant quandary--both economic and moral--over the benefits they provide their employees. So, I think we can all agree that the status quo must go. The question, of course, is what should replace it?

The Clinton Administration has proposed a plan which is designed to address many of the problems I have just raised, as well as many others. Though we have many specific comments on the Clinton plan, I would like to focus my comments on 1) the impact of the mandate on small businesses, including the small business subsidy and payroll-based premiums; and 2) the system of health care alliances that the plan would establish to deal with small business' purchase of health coverage, and the need for competitive purchasing cooperatives. But, before going on, I would like to give you a picture of where NSBU is coming from on health care reform, in order to put our response into perspective.

Our plan for ensuring that all employees of small businesses (and, indeed all Americans) have health coverage has been consistent for almost three years: 1) require everyone to have coverage; 2) reform the insurance system so no one can be denied coverage; and 3) institute a system of federal payments, based upon family income, so that everyone can afford coverage. It is a plan that responds to people, not to businesses; that responds to health care needs, not to employment status.

It is worth noting that NSBU agrees with the importance of all of the health care reform principles laid out by President Clinton during his presentation of the plan: security, simplicity, savings, choice, quality, and responsibility. We think that our own proposal encompasses all of these principles. In fact, we think that many items from our recommendations would actually heighten the President's plan's adherence to these principles. Given our agreement on goals and principles, it is our hope to play a constructive role in the debate and to help design a system with which small businesses can live.

Of course, the details of our plan, like everyone's, become considerably more complex. We have to deal with critical issues such as who gets subsidized, how the plan gets enforced, what goes into a basic benefits package, how tight the insurance bands should be, and--the biggest question--how to keep a lid on costs: but all of these questions can only be addressed once we have decided the answer to the most fundamental question in this debate: Who pays?

A. The Mandate

The Choices

It seems to us that we have three distinct financing options for a universal coverage plan: 1) have the government cover everyone; 2) require employers to cover all of their employees and dependents, with the government picking up the rest; or 3) require all individuals to have coverage, with the government subsidizing those who need it. We have rejected the government-run option on philosophical and substantive grounds. In addition, it is our perception that such a system stands little chance of adoption. Between the two remaining systems, we believe that the individually-based system makes far more sense--for businesses, for individuals, for providers, and for the nation.

Unfortunately, the Clinton Administration has chosen the employer-based approach--and along with it, an elaborate, cumbersome, unequitable, and painfully expensive system of subsidies for many small employers.

Problems With an Employer Mandate

Any employer-based mandate is essentially a payroll tax, but the Clinton plan makes that connection explicit by gearing premium levels to payroll levels for small employers. There are no more damaging taxes to small businesses and their employees than payroll taxes. According to the NSBU survey mentioned earlier, 81 percent of small business owners said that an increase in payroll taxes would have major negative impact on their businesses. They ranked it as the worst thing that could be done to finance health care reform.

Of course, higher payroll taxes add to the cost of current employees, increasing incentives to lower wages and to reduce the numbers of employees. But probably of even greater importance is that these taxes would further raise the hurdle for starting a new business or for hiring an additional employee. The continuous flow of new business start-ups is one of the keys to the success of the U.S. economy. The total number of business start-ups must exceed the total number of failures in order to keep a growing small business community--and the gap between these groups is already closer than many people think. Unfortunately, payroll taxes are likely to increase the failures while making the start-ups more costly and difficult.

We should also remember that payroll taxes must be paid whether a business is currently profitable or not. A highly profitable business will pay the same as one struggling to meet payroll. And this, we feel, is perhaps the greatest problem posed by an employer mandate: its complete lack of flexibility. Under the Clinton plan, small businesses and their employees will no longer have the option of purchasing less expensive insurance in bad economic times, even if the business is quickly losing money. Unfortunately, the major remaining areas of flexibility for the business will be wages and the jobs themselves. This problem is one more reason that we believe that the health care mandate should be severed from the work-place.

The Small Business Subsidy

In an admirable attempt to deal with many of these employer mandate woes, the Clinton plan attempts to help small businesses through an elaborate and extraordinarily expensive system of subsidies. It sounds simple. Businesses with fewer than 50 full-time employees would have a cap on their health care costs of between 3.5 and 7.9 percent of payroll, depending upon its average size. In actual practice, this system could be extraordinarily complex. But there are many questions to which we do not know the answers.

First, how and when is business size computed? Many businesses have greatly fluctuating work-forces and may or may not fit under the 50-employee cap at any given point during the year. Recalculating the payroll cap with every pay period would obviously be very difficult. But using past experience (say, an average from the past year) could be very harmful to businesses in distress. For instance, a business that had 60 employees--and no subsidy--that has had to downsize to 35 employees because of economic hardship would receive no subsidy under a "look-back" procedure, even though it might need and deserve a substantial one.

More difficult still is the calculation about full-time versus part-time employees. Employers would be required to pay a *pro rata* share of premiums for part-time workers, based upon a 30-hour work-week. So, a business would pay 60 percent of the premium for an employee working 18 hours per week, and 33 percent for an employee working 10 hours per week. If an employee works 15 hours per week during one pay period and 25 hours per week the next, does the premium rate change for the employer? Here, a look-back procedure could not really work since many part-time positions are new or temporary and there is no past experience on which to rely. We could go on with the potential practical problems of this type of subsidy for some time, but you get the idea of the kinds of problems we are describing.

An additional problem is the arbitrariness of the subsidy to businesses with fewer than 50 employees. If there are two competitors, one with 45 employees and one with 55 employees, there are probably very few differences between them--except that one could pay more than twice as much for health insurance than the other. There is every incentive for the second employer to get its number of full-time employees down to 50, whether through eliminating positions or simply reducing several employees' weekly hours to below 30. We think this is the wrong basis for critical employment decisions.

So, how would we distribute subsidies differently? Unfortunately, we are only able to be critics of small business subsidies at this point. We can simply think of no way to equitably and effectively distribute health care subsidies to businesses. Do you subsidize the businesses that do not currently provide insurance? Tell that to their competitors who have been providing coverage and will receive no subsidy. Do you subsidize low-wage businesses--thereby encouraging low wages? Do you subsidize low-profit or low-revenue businesses? There are plenty of low-revenue businesses that are highly profitable, and there are plenty of ways to hide profits in order to collect federal dollars. Frankly, we are skeptical about whether there is a way to fairly subsidize businesses for health insurance, which is just one more reason we have rejected an employer mandate as the appropriate avenue for universal coverage. And it is one more reason that we support health care subsidies for *individuals*, based upon their ability to pay.

One of the primary reasons for considering an employer mandate has always been that significant employer financing relieves the federal government of the need to finance the care of any low-income individuals. Since an employer mandate avoids a lot of federal spending, it requires fewer new taxes and becomes more politically popular. Of course, we have a lot of trouble with a government that wants to avoid the tough choice of cutting spending or raising taxes--even for appropriate societal responsibilities--yet that insists on shifting those responsibilities to small businesses. But on a more practical level, we wonder whether the employer mandate in the Clinton plan saves the government any money at all. After all, the mandate is slated to cost almost $450 billion over five years in small business subsidies alone. In its zeal to make the mandate work, has the Administration forgotten one of the fundamental arguments for an employer mandate? We think that an individual mandate could be targeted to

cost less than these government subsidies to small businesses, without all of the attendant equity and implementation problems.

Individual Mandate

As President Clinton has so consistently and correctly pointed out, small business is the engine that drives job creation and economic growth in this nation. Small businesses employ 57 percent of the private work force, make 54 percent of all sales, and contribute 50 percent of the gross domestic product. In the last decade, small businesses created the vast majority of new jobs. Yet, we also have to remember that small business jobs are more likely to be filled by younger workers, older workers, women, and part-time workers. Unfortunately, a health care mandate that drains tens of billions of dollars out of small businesses every year will put a dramatic damper on job creation and economic growth, affecting those workers and the businesses that employ them most of all.

Please understand where we are coming from: an individual approach is not an attempt by small business to duck responsibility for the health of their employees; over 80 percent of small business employees and their dependents have insurance. An individual mandate will not cause those businesses currently providing insurance to drop it. In fact, we think that requiring all individuals to participate in the system would actually increase the pressure that employees place on their employers to provide that coverage for them, causing employer-provided coverage to increase. Yet, there are situations where the added expense of health insurance would cause wage deflation, lost jobs, and even business closings. A system that responds to the needs of the employees and families of such businesses--on an individual basis--would be the best system. As important as it is to provide access to quality health care for all, we think that employment and jobs should receive equal attention, especially when there is a conflict between these two

needs. Moreover, we believe that this model is the only one that can cut costs, maintain and expand choice, preserve quality of care, reduce redundancy and unnecessary care, maintain the jobs and economic growth capacity of the small business community, and provide health care for all.

B. Health Alliances

Single, Regional Alliances

Under the Clinton plan, all employees of businesses with fewer than 5,000 employees would be enrolled in their regional health alliance, to which their individual and employer premiums would flow. Once in the alliance, the individuals would choose from the various health plans that qualify to be offered by the alliance. At no point in the process are small employers, who will be paying most of the bill for their employees, given a choice or allowed any avenue to find a better value for their money--and they are certainly not given the chance to actually save money.

Under the Clinton plan, the health alliances will have far-reaching responsibilities--from enforcing budgets to delivering provider information to individual members. It seems unlikely that this large and busy bureaucracy will find creative ways to encourage competition and innovation. There may need to be some sort of "health alliance" at the local level to coordinate provider expenditures and provide a framework for community-wide health care decisions. But these roles should be separated from the purchasing cooperative role, which is simply to bring businesses together to bargain for the best deal on coverage for their employees. Unfortunately, this dynamic cannot occur in the Clinton plan.

How are we to bring competitive forces to bear for cost containment when those who are paying are not allowed to make any choices for their dollars?

Competing Purchasing Cooperatives

Small businesses should have the right to organize and run their own health care purchasing cooperatives, in order to have choice and empowerment within the system. A mandate on employers which provides neither an avenue for these businesses to choose how to purchase coverage nor an ability to organize for their own best interests and survival will be very unpopular with small business. Many businesses which currently provide coverage, and might not oppose an employer mandate, will almost certainly oppose a provision which traps them into purchasing coverage from a single--potentially inefficient--source.

Moreover, we believe that private competing health alliances are essential for maximizing competitive forces for cost containment. Competing cooperatives will have strong incentives to negotiate tough deals with providers, in order to attract members. In areas where the market cannot sustain multiple cooperatives, they will not exist, thereby maintaining the efficiencies of larger pools. Multiple cooperatives represent an important component for maximizing the cost containment potential of managed competition.

The Administration has been appropriately nervous about allowing single, monopolistic (and monopsonistic, depending upon your point of view) health alliances to exclude health plans from participation in the alliance. The only mechanism the alliances would have to exclude plans would be a price cap and several other objective standards. But competing alliances could actually bargain with insurers and provider groups for the best deals for their members, and

groups that would not deal could be excluded from the alliance. The competing alliances' ability to exclude insurers and provider groups would be one of their most powerful cost containment tools.

The Administration's plan allows large corporations with more than 5,000 lives to opt out of the health alliance system and self-insure. They will only do so if that action enables them to save money. Small businesses are given no similar opportunities to find cost savings in the system. Small businesses need this kind of flexibility even more than their larger counterparts. Moreover, even in a system of competing health care purchasing cooperatives, we believe that the ceiling for business participation should be much lower than 5,000 lives.

Risk Selection

Some opponents of competing health cooperatives have argued that competing health alliances will foster adverse selection problems, causing many of the plans to descend into a doomed "death spiral." We simply think that these arguments are somewhat overblown and should not be viewed as an insurmountable problem. If all individuals must have coverage, and all providers and alliances must offer coverage and accept individuals under the same conditions, we believe that the risk selection problems will be relatively minor.

But, if necessary, there are several ways to deal with potential risk selection problems in a competitive purchasing cooperative environment. Since adverse selection has primarily to do with individuals "gaming" the system for their own benefit (sick people enrolling in the most expansive plans and young healthy individuals choosing HMOs), we expect most risk selection problems to occur *within* the purchasing cooperatives, rather than *between* them. Within the purchasing cooperatives a risk adjuster could be used, just as the Administration plans to use in

their health alliances' health plans, which will have the same problems. Such a risk-adjuster would essentially allow insurers to insure against having too many unhealthy individuals in a plan. This mechanism will spread the costs of caring for the sick equitably across all carrier groups.

In a system of competing health purchasing cooperatives, businesses would be making the decisions about which cooperative to join, so the individual risk selection problem would not exist. Any risk selection would occur from the relatively subtle marketing decisions of the purchasing cooperatives. For instance, purchasing cooperatives could choose to only market their services to "better risk" businesses in better risk areas--assuming these non-profit entities were wily enough to have that knowledge. But it would be relatively simple to circumvent this problem by informing all businesses of all purchasing cooperatives which are available, along with a thorough description. And if cooperatives attempt to serve one part of a region differently than another, it would be easy enough for the states to draw boundaries in a way to make this practice at least very difficult.

Again, competing purchasing cooperatives are likely to provide greater cost containment than single alliances; competing cooperatives can be structured to avoid risk selection problems at least as well as single health alliances; competing cooperatives provide small businesses with empowerment in the system, room to maneuver without feeling "locked-in", and a role in overall cost containment. We think that the issue of competing purchasing cooperatives will ultimately be one of the key small business issues in this debate, unless it is addressed early-on.

III. Conclusion

We appreciate being invited to testify today. National Small Business United wants fundamental reform of the health care system; we believe that such reform is critical to the long-term survival and growth of small businesses. But the new system must make economic sense, and it must take the unique problems and limits of small businesses into account. As you might guess, we have many other comments on many other aspects of the Clinton plan. If there is any further input that we might be able to provide to the Committee, we will be pleased to do so. Thank you.

Chairman WILLIAMS. Mr. Helms, do you support universal coverage?

Mr. HELMS. I am not—yes, I think so.

Let me qualify that. I am not so sure that we can afford it right away. If we get universal coverage, I think it would be an enormous cost.

Chairman WILLIAMS. You were here for those four women who preceded you.

Mr. HELMS. Yes.

Chairman WILLIAMS. What about the cost to them? What about continuing that kind of cost for millions of Americans if you don't have universal coverage?

Mr. HELMS. That is what I mean by the kind of reform that I think would get an efficient market working here. I think you can get the universal coverage in a market sense as outlined in a plan that AEI published called the Pauly Plan, but it does take some cost and an amount of regulation to do it. They did attempt to do it in a market sense.

I think the objective is that if you can get the right kind of reform you would get a different kind of insurance, and I think you would get more people competing not only on the base of price but to service those kinds of people and to give them good quality coverage and to get larger business network groups that would provide insurance, maybe more in a catastrophic sense. Because one of the things that has happened is we have gotten away from the concept of insurance. We have put a lot of things into insurance that make it more like prepayment of medical expenses as opposed to the concept of insurance which would cover for the large, low-probability events, which is the normal way we look at insurance in other areas.

Chairman WILLIAMS. Mrs. Roukema.

Mrs. ROUKEMA. Thank you.

My questions—a number of questions. Dr. Helms noted that I probably don't agree with him with respect to tax policy as I outlined in my——

Mr. HELMS. That is a truly bipartisan problem.

Mrs. ROUKEMA. It is a bipartisan problem. You made the statement that there are distorted incentives rather than market incentives. I know that rhetoric. I hear it all the time. But I don't understand it because you come up against real-life issues, and I don't know what those distorted incentives are. One I think you have just referred to belatedly and that is that it shouldn't be general coverage, it should be only catastrophic coverage. Is that what you think the distorted incentives are here?

Mr. HELMS. That is one of the outcomes. In a competitive insurance market people would have choices. They could buy the catastrophic for a lower cost.

Mrs. ROUKEMA. Everybody says we don't have a competitive system and yet I find that everything is competitive out there. We have all kinds of competitive insurance programs, do we not?

Mr. HELMS. Yes, but you have to look at it in terms of the history of what happened to health insurance, the dominance of the Blues in an early period and the decline of community rating and then a system which I think even the insurance industry views as an

insurance market which has failed, that it is much competition on the basis of risk as opposed to competing on the basis of service and price. It is a type of competition.

By the way, I do try to cover that a bit in my testimony.

Mrs. ROUKEMA. All right. I will go over your testimony. I just want to say that some of us would argue that this system has afforded most Americans, not all, but most Americans, the most advanced health care system in the world.

Mr. HELMS. I agree.

Mrs. ROUKEMA. Then how would we maintain that status and that standard and still do what you are suggesting. In other words, how would we make the Federal payments? If you don't mandate it to business and have it as a component of employment and you don't have a direct subsidy to business, what is the Federal payment? How do you make the Federal payment? Because individuals cannot afford this on their own particularly low wage.

Mr. HELMS. Well, one example, in the Pauly Plan—and there is a similar procedure also in the Heritage Plan—they take the tax revenue that they would get from eliminating the exclusion and try to use it to expand coverage on the basis of income.

Mrs. ROUKEMA. The number is $50 billion, and they transfer it to medicaid. That is the way the business people in my district have explained it to me.

Mr. HELMS. The proposals I am familiar with don't just expand it to medicaid, although you could expand medicaid. They do it with an income-based tax credit approach.

Mrs. ROUKEMA. You are correct as far as the Heritage and AEI group. The approach I have heard is a different business approach. You are right. I do recall that.

Would either of you gentlemen, maybe Mr. Galles, like to comment on the exponential growth, the astronomical explosion in insurance rates that small businesses have tried to absorb? Can you account for it? What components go into that astronomical explosion?

Mr. GALLES. I think they have grown so dramatically for small businesses because they have not been able to adequately confront the health care system collectively. They are left adrift as individual businesses in most circumstances.

And hospital and provider communities see their financing basically coming from three directions: from the government for those people who are uninsured or underinsured, from larger corporations which have negotiated substantial benefits and then go to provider communities and negotiate fees for services which may be less than they are charging for them. Then those provider communities turn to the privately insured community and charge them substantially more.

Even Dr. Laura Tyson's testimony, she admitted that the privately insured were paying 130 percent of their costs.

Mrs. ROUKEMA. Cost shifting.

Mr. GALLES. I think that that answers it substantially. Forty percent of our health care costs are coming from the Federal Government, another 30 percent are coming from the self-insured communities, and the rest of us are the 30 percent who are so

disenfranchised and such individual purchasers that we can't collectively get in there and negotiate for our own position.

Mrs. ROUKEMA. I share your concern about the monolithic single alliances. I don't know what the alternative is. I don't know how efficiently we can put small businesses into smaller cooperatives. I would like to think that we could do that because I am concerned——

Mr. GALLES. It is essential for those to take off, that the government do something about insurance reform. Because I can tell you right now, we are trying to organize a privately organized purchasing cooperative in California. We have 14 carriers that are talking to us about participating in that entity. But one of the biggest debates we have as a group has to do with underwriting and rating practices. And as long as we are in the market we are today we end up having to work out arrangements that allow them to compete without taking on all of the bad business that would get dumped on us if we were simply community rated no underwriting cooperatives. So you could go a long way to help us by doing some of that immediately.

Mrs. ROUKEMA. Thank you. I think we agree on some of the problems.

Dr. Helms, I think you know there is at least one person on the minority on this subcommittee that agrees with you totally, and I am sorry that person isn't here to endorse all your positions, and there may be more than one. I happen to maintain a healthy skepticism about it, but we are going to try to accommodate in other ways and seek a realistic resolution to our problem because there is a problem out there, and I don't believe the administration has yet found the answer to that problem. But we will work through it together.

Mr. HELMS. I don't think they have, either.

Mrs. ROUKEMA. Thank you very much. I appreciate your attending here today.

Chairman WILLIAMS. Let me join my colleague in expressing my thanks for coming and the thanks of other members of our committee who weren't able to be here. Your testimony will be made available to each of the members of the committee, and I know many of them go through the testimony. You have been very helpful and I think raised interesting and important questions, and we appreciate very much your good counsel. Thank you for being here.

The hearing is adjourned.

[Whereupon, at 1:10 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows.]

STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Thank you Mr. Chairman. I wish to thank our witnesses for joining us this morning. There is a growing consensus in the Nation that our health care system which is the best in the world still does not meet all our needs. It lacks adequacy and accessibility for urban and rural communities. No one can deny that reform of our health care system is needed.

One of the greatest fears which my constituents have stated to me is the fear that the reform will increase cost. We must overcome this fear. The hearings that the Chairman has called will moderate some of the fear by providing information. But nothing is more fearful than having an ill family member and being unable to access our health care system. Health care costs have increased to a level where many Americans are forced out of the health insurance market.

Our focus today is the administration's proposal and how it deals with the cost of health care for the individual. It is my hope that during the hearing process we are able to find a method to lower cost without negatively affecting both choice and quality of health care. I do not wish to hinder or punish the health care system due to a perception of uncontrolled cost increases in the past.

The administration's proposal calls for greater choice than most of my constituents have as of today. I believe increasing this choice for every American regardless of urban or rural residence is the basis of the President's reform plan and should be maintained.

Thank you Mr. Chairman.

IN THE UNITED STATES COURT OF APPEALS

FOR THE FIFTH CIRCUIT

No. 91-3322

FLORENCE B. CORCORAN
Wife of/and WAYNE D. CORCORAN,

Plaintiffs-Appellants,

v.

UNITED HEALTHCARE, INC.,
and BLUE CROSS and BLUE SHIELD
OF ALABAMA, INC.,

Defendants-Appellees.

Appeal from the United States District Court
for the Eastern District of Louisiana

Before THORNBERRY, KING, and DeMOSS, Circuit Judges.

KING, Circuit Judge:

This appeal requires us to decide whether ERISA pre-empts a state-law malpractice action brought by the beneficiary of an ERISA plan against a company that provides "utilization review" services to the plan. We also address the availability under ERISA of extracontractual damages. The district court granted the defendants' motion for summary judgment, holding that ERISA both pre-empted the plaintiffs' medical malpractice claim and precluded them from recovering emotional distress damages. We affirm.

I. BACKGROUND

The basic facts are undisputed. Florence Corcoran, a long-time employee of South Central Bell Telephone Company (Bell), became pregnant in early 1989. In July, her obstetrician, Dr. Jason Collins, recommended that she have complete bed rest during the final months of her pregnancy. Mrs. Corcoran applied to Bell for temporary disability benefits for the remainder of her pregnancy, but the benefits were denied. This prompted Dr. Collins to write to Dr. Theodore J. Borgman, medical consultant for Bell, and explain that Mrs. Corcoran had several medical problems which placed her "in a category of high risk pregnancy." Bell again denied disability benefits. Unbeknownst to Mrs. Corcoran or Dr. Collins, Dr. Borgman solicited a second opinion on Mrs. Corcoran's condition from another obstetrician, Dr. Simon Ward. In a letter to Dr. Borgman, Dr. Ward indicated that he had reviewed Mrs. Corcoran's medical records and suggested that "the company would be at considerable risk denying her doctor's recommendation." As Mrs. Corcoran neared her delivery date, Dr. Collins ordered her hospitalized so that he could monitor the fetus around the clock.[1]

Mrs. Corcoran was a member of Bell's Medical Assistance Plan (MAP or "the Plan"). MAP is a self-funded welfare benefit plan which provides medical benefits to eligible Bell employees. It

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[1] This was the same course of action Dr. Collins had ordered during Mrs. Corcoran's 1988 pregnancy. In that pregnancy, Dr. Collins intervened and performed a successful Caesarean section in the 36th week when the fetus went into distress.

is administered by defendant Blue Cross and Blue Shield of Alabama (Blue Cross) pursuant to an Administrative Services Agreement between Bell and Blue Cross. The parties agree that it is governed by ERISA.[2] Under a portion of the Plan known as the "Quality Care Program" (QCP), participants must obtain advance approval for overnight hospital admissions and certain medical procedures ("pre-certification"), and must obtain approval on a continuing basis once they are admitted to a hospital ("concurrent review"), or plan benefits to which they otherwise would be entitled are reduced.

QCP is administered by defendant United HealthCare (United) pursuant to an agreement with Bell. United performs a form of cost-containment services that has commonly become known as "utilization review." See Blum, An Analysis of Legal Liability in Health Care Utilization Review and Case Management, 26 Hous. L. Rev. 191, 192-93 (1989) (utilization review refers to "external evaluations that are based on established clinical criteria and are conducted by third-party payors, purchasers, or health care organizers to evaluate the appropriateness of an episode, or series of episodes, of medical care."). The Summary Plan Description (SPD) explains QCP as follows:

> The Quality Care Program (QCP), administered by United HealthCare, Inc., assists you and your covered dependents in securing quality medical care according to the provisions of the Plan while helping reduce risk and expense due to unnecessary hospitalization and surgery. They do this by providing you with information which will permit you (in

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[2] Employee Retirement Income Security Act of 1974, Pub. L. 93-406, 88 Stat. 829, 29 U.S.C. §§ 1001-1461.

> consultation with your doctor) to evaluate alternatives to surgery and hospitalization when those alternatives are medically appropriate. In addition, QCP will monitor any certified hospital confinement to keep you informed as to whether or not the stay is covered by the Plan.

Two paragraphs below, the SPD contains this statement: When reading this booklet, remember that all decisions regarding your medical care are up to you and your doctor. It goes on to explain that when a beneficiary does not contact United or follow its pre-certification decision, a "QCP Penalty" is applied. The penalty involves reduction of benefits by 20 percent for the remainder of the calendar year or until the annual out-of-pocket limit is reached. Moreover, the annual out-of-pocket limit is increased from $1,000 to $1,250 in covered expenses, not including any applicable deductible. According to the QCP Administrative Manual, the QCP penalty is automatically applied when a participant fails to contact United. However, if a participant complies with QCP by contacting United, but does not follow its decision, the penalty may be waived following an internal appeal if the medical facts show that the treatment chosen was appropriate.

A more complete description of QCP and the services provided by United is contained in a separate booklet. Under the heading "WHAT QCP DOES" the booklet explains:

> Whenever your doctor recommends surgery or hospitalization for you or a covered dependent, QCP will provide an independent review of your condition (or your covered dependent's). The purpose of the review is to assess the need for surgery or hospitalization and to determine the appropriate length of stay for a hospitalization, based on nationally accepted medical guidelines. As part of the review process, QCP will discuss with your doctor the

> appropriateness of the treatments recommended and the availability of alternative types of treatments -- or locations for treatment -- that are equally effective, involve less risk, and are more cost effective.

The next paragraph is headed "INDEPENDENT, PROFESSIONAL REVIEW" and states:

> United Health Care, an independent professional medical review organization, has been engaged to provide services under QCP. United's staff includes doctors, nurses, and other medical professionals knowledgeable about the health care delivery system. Together with your doctor, they work to assure that you and your covered family members receive the most appropriate medical care.

At several points in the booklet, the themes of "independent medical review" and "reduction of unnecessary risk and expense" are repeated. Under a section entitled "THE QUALITY CARE PROGRAM...AT A GLANCE" the booklet states that QCP "Provides independent, professional review when surgery or hospitalization is recommended -- to assist you in making an enlightened decision regarding your treatment." QCP "provides improved quality of care by eliminating medically unnecessary treatment," but beneficiaries who fail to use it "may be exposed to unnecessary health risks. . . ." Elsewhere, in the course of pointing out that studies show one-third of all surgery may be unnecessary, the booklet explains that programs such as QCP "help reduce unnecessary and inappropriate care and eliminate their associated costs." Thus, "one important service of QCP will help you get a second opinion when your doctor recommends surgery."

The booklet goes on to describe the circumstances under which QCP must be utilized. When a Plan member's doctor recommends admission to the hospital,

> [i]ndependent medical professionals will review, with the patient's doctor, the medical findings and the proposed course of treatment, including the medically necessary length of confinement. The Quality Care Program may require additional tests or information (including second opinions), when determined necessary during consultation between QCP professionals and the attending physician.

When United certifies a hospital stay, it monitors the continuing necessity of the stay. It also determines, for certain medical procedures and surgeries, whether a second opinion is necessary, and authorizes, where appropriate, certain alternative forms of care. Beneficiaries are strongly encouraged to use QCP to avoid loss of benefits: "'fully using' QCP means following the course of treatment that's recommended by QCP's medical professionals."

In accordance with the QCP portion of the plan, Dr. Collins sought pre-certification from United for Mrs. Corcoran's hospital stay. Despite Dr. Collins's recommendation, United determined that hospitalization was not necessary, and instead authorized 10 hours per day of home nursing care.[3] Mrs. Corcoran entered the hospital on October 3, 1989, but, because United had not pre-certified her stay, she returned home on October 12. On October 25, during a period of time when no nurse was on duty, the fetus went into distress and died.

Mrs. Corcoran and her husband, Wayne, filed a wrongful death action in Louisiana state court alleging that their unborn child died as a result of various acts of negligence committed by Blue Cross and United. Both sought damages for the lost love, society

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[3] The record does not reveal the name of the person or persons at United that made the decision concerning Mrs. Corcoran.

and affection of their unborn child. In addition, Mrs. Corcoran sought damages for the aggravation of a pre-existing depressive condition and the loss of consortium caused by such aggravation, and Mr. Corcoran sought damages for loss of consortium. The defendants removed the action to federal court on grounds that it was pre-empted by ERISA[4] and that there was complete diversity among the parties.

Shortly thereafter, the defendants moved for summary judgment. They argued that the Corcorans' cause of action, properly characterized, sought damages for improper handling of a claim from two entities whose responsibilities were simply to administer benefits under an ERISA-governed plan. They contended that their relationship to Mrs. Corcoran came into existence solely as a result of an ERISA plan and was defined entirely by the plan. Thus, they urged the court to view the claims as "relating to" an ERISA plan, and therefore within the broad scope of state law claims pre-empted by the statute. In their opposition to the motion, the Corcorans argued that "[t]his case essentially boils down to one for malpractice against United HealthCare. . . ." They contended that under this court's analysis in Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc., 793 F.2d 1456 (5th Cir. 1986), cert. denied, 479 U.S. 1034 (1987), their cause of action must be

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[4] See Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 66 (1987) (because ERISA pre-emption is so comprehensive, pre-emption defense provides sufficient basis for removal to federal court notwithstanding "well-pleaded complaint" rule).

classified as a state law of general application which involves an exercise of traditional state authority and affects principal ERISA entities in their individual capacities. This classification, they argued, together with the fact that pre-emption would contravene the purposes of ERISA by leaving the Corcorans without a remedy, leads to the conclusion that the action is permissible notwithstanding ERISA.

The district court, relying on the broad ERISA pre-emption principles developed by the Supreme Court and the Fifth Circuit, granted the motion. The court noted that ERISA pre-emption extends to state law claims "'of general application,' including tort claims where ERISA ordinarily plays no role in the state law at issue." (citing Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58 (1987) and Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987)). The court found that the state law claim advanced by the Corcorans "relate[d] to" the employee benefit plan (citing the statutory pre-emption clause, ERISA § 514(a)), and therefore was pre-empted, because

> [b]ut for the ERISA plan, the defendants would have played no role in Mrs. Corcoran's pregnancy; the sole reason the defendants had anything to do with her pregnancy is because the terms of the ERISA plan directed Mrs. Corcoran to the defendants (or at least to United HealthCare) for approval of coverage of the medical care she initially sought.

The court held that, because the ERISA plan was the source of the relationship between the Corcorans and the defendants, the Corcorans' attempt to distinguish United's role in paying claims from its role as a source of professional medical advice was unconvincing.

The Corcorans filed a motion for reconsideration under Rule 59 of the Federal Rules of Civil Procedure. They did not ask the district court to reconsider its pre-emption ruling, but instead contended that language in the district court's opinion had implicitly recognized that they had a separate cause of action under ERISA's civil enforcement mechanism, § 502(a)(3).[5] They argued that the Supreme Court's decision in Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134 (1985), did not foreclose the possibility that compensatory damages such as they sought constituted "other appropriate equitable relief" available under § 502(a)(3) for violations of ERISA or the terms of an ERISA plan. The district court denied the motion. Although the court recognized that there was authority to the contrary, it pointed out that "[t]he vast majority of federal appellate courts have . . . held that a beneficiary under an ERISA health plan may not recover under section 509(a)(3) [sic] of ERISA compensatory or consequential damages for emotional distress or other claims beyond medical expenses covered by the plan." (citations omitted). Moreover, the court pointed out, a prerequisite to recovery under § 502(a)(3) is a violation of the terms of ERISA itself. ERISA does not place upon the defendants a substantive

[5] The district court had stated that "[b]ecause the plaintiffs concede that the defendants have fully paid any and all medical expenses that Mrs. Corcoran actually incurred that were covered by the plan, the plaintiffs have no remaining claims under ERISA." In a footnote, the court indicated that Mrs. Corcoran could have (1) sued under ERISA, before entering the hospital, for a declaratory judgment that she was entitled to hospitalization benefits; or (2) gone into the hospital, incurred out-of-pocket expenses, and sued under ERISA for these expenses.

responsibility in connection with the provision of medical advice which, if breached, would support a claim under § 502(a)(3). The court entered final judgment in favor of Blue Cross and United, and this appeal followed.

II. STANDARD OF REVIEW

Because this case is on appeal from the district court's grant of summary judgment, our review is plenary. Dorsett v. Board of Trustees for State Colleges & Universities, 940 F.2d 121, 123 (5th Cir. 1991). We view the evidence in the light most favorable to the nonmoving party, id., and must affirm if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). As this case currently stands, the parties dispute not the relevant facts, but the legal conclusions that must be applied to those facts. As the Corcorans put it, "[t]he question on appeal is whether the plaintiffs are afforded any relief, under state law or ERISA, for damages caused by [the defendants' actions]."

III. PRE-EMPTION OF THE STATE LAW CAUSE OF ACTION

A. The Nature of the Corcorans' State Law Claims

The Corcorans' original petition in state court alleged that acts of negligence committed by Blue Cross and United caused the

death of their unborn child. Specifically, they alleged that Blue Cross wrongfully denied appropriate medical care, failed adequately to oversee the medical decisions of United, and failed to provide United with Mrs. Corcoran's complete medical background. They alleged that United wrongfully denied the medical care recommended by Dr. Collins and wrongfully determined that home nursing care was adequate for her condition. It is evident that the Corcorans no longer pursue any theory of recovery against Blue Cross. Although they mention in their appellate brief the fact that they asserted a claim against Blue Cross, they challenge only the district court's conclusion that ERISA pre-empts their state law cause of action against United.[6] We, therefore, analyze solely the question of pre-emption of the claims against United. See Hulsey v. State of Texas, 929 F.2d 168, 172 (5th Cir. 1991) (issues stated but not briefed need not be considered on appeal).

The claims against United arise from a relatively recent phenomenon in the health care delivery system -- the prospective review by a third party of the necessity of medical care. Systems of prospective and concurrent review, rather than traditional retrospective review, were widely adopted throughout the 1980s as a method of containing the rapidly rising costs of health care. Blum, supra, at 192; Furrow, Medical Malpractice and Cost Containment: Tightening the Screws, 36 Case Western L.

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[6] They also do not mention Blue Cross when arguing that extracontractual damages are available under § 502(a)(3).

Rev. 985, 986-87 (1986). Under the traditional retrospective system (also commonly known as the fee-for-service system), the patient obtained medical treatment and the insurer reviewed the provider's claims for payment to determine whether they were covered under the plan. Denial of a claim meant that the cost of treatment was absorbed by an entity other than the one designed to spread the risk of medical costs -- the insurer.

Congress's adoption in 1983 of a system under which hospitals are reimbursed for services provided to Medicare patients based upon average cost calculations for patients with particular diagnoses spurred private insurers to institute similar programs in which prospective decisions are made about the appropriate level of care. Although plans vary, the typical prospective review system requires some form of pre-admission certification by a third party (e.g., the HMO if an HMO-associated doctor provides care; an outside organization such as United if an independent physician provides care) before a hospital stay. Concurrent review involves the monitoring of a hospital stay to determine its continuing appropriateness. See generally, Blum, supra, at 192-93; Tiano, The Legal Implications of HMO Cost Containment Measures, 14 Seton Hall Legis. J. 79, 80 (1990). As the SPD makes clear, United performs this sort of prospective and concurrent review (generically, "utilization review") in connection with, inter alia, the hospitalization of Bell employees.

The Corcorans based their action against United on Article 2315 of the Louisiana Civil Code, which provides that "[e]very act whatever of man that causes damage to another obliges him by whose fault it happened to repair it." Article 2315 provides parents with a cause of action for the wrongful death of their unborn children, Danos v. St. Pierre, 402 So. 2d 633, 637-38 (La. 1981), and also places liability on health care providers when they fail to live up to the applicable standard of care. Chivleatto v. Divinity, 379 So. 2d 784, 786 (La. Ct. App. 4th Dist. 1979). Whether Article 2315 permits a negligence suit against a third party provider of utilization review services, however, has yet to be decided by the Louisiana courts. The potential for imposing liability on these entities is only beginning to be explored, with only one state explicitly permitting a suit based on a utilization review company's allegedly negligent decision about medical care to go forward. Wilson v. Blue Cross of So. California, 22 Cal. App. 3d 660, 271 Cal. Rptr. 876, 883 (1990) (reversing summary judgment for utilization review company which determined that further hospitalization was not necessary; ERISA not implicated);[7] see also Wickline v. State of California, 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810, 819 (1986) (stating, in dicta, that negligent implementation of cost containment mechanisms such as utilization

[7] The case went to trial, but the plaintiff settled with Western Medical, the provider of utilization review services. See Milt Freudenheim, When Treatment and Costs Collide, N.Y. Times, Apr. 28, 1992, at C2 col. 1.

review can lead to liability; ERISA not implicated), cert. granted, 727 P.2d 753, 231 Cal. Rptr. 560, review dismissed, cause remanded, 741 P.2d 613, 239 Cal. Rptr. 805 (1987).[8]

In the absence of clear Louisiana authority for their lawsuit, the Corcorans rely on Green v. Walker, 910 F.2d 291 (5th Cir. 1990). We held in Green that Article 2315 imposes a duty of due care upon physicians hired by employers to conduct employment-related exams on employees. Id. at 296. The cause of action recognized in Green, however, is not analogous to the

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[8] Numerous commentators have weighed in on the propriety of liability for utilization review decisions. See e.g., Macaulay, Health Care Cost Containment and Medical Malpractice: On a Collision Course, 19 Suffolk U.L. Rev. 91, 106-107 (1986) (arguing for higher standard of negligence in "Wickline suits"); Morreim, Cost Containment and the Standard of Medical Care, 75 Calif. L. Rev. 1719, 1749-50 (1987) (arguing that liability should be limited because patient's physician makes the ultimate decision about treatment); Note, Paying the Piper: Third Party Payor Liability for Medical Treatment Decisions, 25 Ga. L. Rev. 861, 907-911 (1991) (by David Griner) (arguing that without liability for negligence in utilization review decisions, third party payors have incentives to control costs but not to use reasonable care in the decisionmaking process); Mellas, Adapting the Judicial Approach to Medical Malpractice Claims Against Physicians to Reflect Medicare Cost Containment Measures, 62 U. Colo. L. Rev. 287, 316 (1991) (liability will reduce possibility that poor medical decisions will be made in order to cut costs).

Even if courts put their imprimatur on negligence actions against utilization review organizations, plaintiffs would face difficulties in proving that the organization's decision was a significant cause of an injury. See Wickline, 239 Cal. Rptr. at 819 (decision of doctor to discharge patient after Medi-Cal (state utilization review body) would not authorize additional hospital stay, not decision of Medi-Cal on appropriate length of stay, is act upon which liability should be premised); Note, supra, 25 Ga. L. Rev. at 902-05 (discussing problem of proving that utilization review organization's decision is proximate cause of injury); but see Wilson, 271 Cal. Rptr. at 883 (finding that plaintiffs had adduced enough evidence as to causal effect of utilization review company's decision on decedent's suicide to avoid summary judgment).

cause of action brought against United because Green involved an actual physical examination by a doctor hired by an employer, not the detached decision of a utilization review company. Despite the lack of clear Louisiana authority supporting the Corcorans' theory of recovery against United, we can resolve the pre-emption question presented in this appeal. The law in this area is only beginning to develop, and it does not appear to us that Louisiana law clearly forecloses the possibility of recovery against United. Thus, assuming that on these facts the Corcorans might be capable of stating a cause of action for malpractice,[9] our task now is to determine whether such a cause of action is pre-empted by ERISA.

B. Principles of ERISA Pre-emption

The central inquiry in determining whether a federal statute pre-empts state law is the intent of Congress. FMC Corp. v. Holliday, 111 S. Ct. 403, 407 (1990); Allis-Chalmers Corp. v. Lueck, 471 U.S. 202, 208 (1985). In performing this analysis we begin with any statutory language that expresses an intent to pre-empt, but we look also to the purpose and structure of the statute as a whole. FMC Corp., 111 S. Ct. at 407; Ingersoll-Rand Co. v. McClendon, 111 S. Ct. 478, 482 (1990).

ERISA contains an explicit pre-emption clause, which provides, in relevant part:

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[9] If the Corcorans could sue United on a negligence theory, it would appear that they could recover damages incurred in connection with the death of their unborn child. Danos, 402 So. 2d at 637.

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a). . . .

ERISA § 514(a).[10] It is by now well-established that the "deliberately expansive" language of this clause, Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 42, 46 (1987), is a signal that it is be construed extremely broadly. See FMC Corp., 111 S. Ct. at 407 ("[t]he pre-emption clause is conspicuous for its breadth"); Ingersoll-Rand, 111 S. Ct. at 482.[11] The key words

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[10] Statutory, decisional and all other forms of state law are included within the scope of the preemption clause. ERISA § 514(c)(1) ("The term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State"). Section 514(b)(2)(A) exempts certain state laws from pre-emption, but none of these exemptions is applicable here.

[11] The legislative history indicates that Congress intended the preemption provision to be applied expansively. In Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983), the Court explained:

> The bill that became ERISA originally contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected those provisions in favor of the present language, and indicated that section's pre-emptive scope was as broad as its language. See H.R. Conf. Rep. No. 93-1280, p. 383 (1974); S. Conf. Rep. No. 93-1090, p. 383 (1974).

463 U.S. at 98. Senator Williams, one of ERISA's sponsors, remarked:

> It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.

"relate to" are used in such a way as to expand pre-emption beyond state laws that relate to the specific subjects covered by ERISA, such as reporting, disclosure and fiduciary obligations. Id. at 482. Thus, state laws "relate[] to" employee benefit plans in a much broader sense -- whenever they have "a connection with or reference to such a plan." Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97 (1983). This sweeping pre-emption of state law is consistent with Congress's decision to create a comprehensive, uniform federal scheme for the regulation of employee benefit plans. See Ingersoll-Rand, 111 S. Ct. at 482; Pilot Life, 481 U.S. at 45-46.

The most obvious class of pre-empted state laws are those that are specifically designed to affect ERISA-governed employee benefit plans. See Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 829-30 (1988) (statute explicitly barring garnishment of ERISA plan funds is pre-empted); Ingersoll-Rand, 111 S. Ct. at 483 (cause of action allowing recovery from employer when discharge is premised upon attempt to avoid contributing to pension plan is pre-empted). But a law is not saved from pre-emption merely because it does not target employee benefit plans. Indeed, much pre-emption litigation involves laws of general application which, when applied in particular settings, can be said to have a connection with or a reference to an ERISA plan. See Pilot Life, 481 U.S. at 47-48 (common law

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120 Cong. Rec. 29933 (1974). See also Pilot Life, 481 U.S. at 46.

tort and contract causes of action seeking damages for improper processing of a claim for benefits under a disability plan are pre-empted); Shaw, 463 U.S. at 95-100 (statute interpreted by state court as prohibiting plans from discriminating on the basis of pregnancy is pre-empted); Christopher v. Mobil Oil Corp., 950 F.2d 1209, 1218 (5th Cir. 1992) (common law fraud and negligent misrepresentation claims that allege reliance on agreements or representations about the coverage of a plan are pre-empted), petition for cert. filed 60 U.S.L.W. 3829 (U.S. May 26, 1992) (No. 91-1881); Lee v. E.I. DuPont de Nemours & Co., 894 F.2d 755, 758 (5th Cir. 1990) (same). On the other hand, the Court has recognized that not every conceivable cause of action that may be brought against an ERISA-covered plan is pre-empted. "Some state actions may affect employee benefit plans in too tenuous, remote or peripheral a manner to warrant a finding that the law 'relates to' the plan." Shaw, 463 U.S. at 100 n.21. Thus, "run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan" are not pre-empted, Mackey, 486 U.S. at 833 (discussing these types of claims in dicta).

C. Pre-emption of the Corcorans' Claims

Initially, we observe that the common law causes of action advanced by the Corcorans are not that species of law "specifically designed" to affect ERISA plans, for the liability rules they seek to invoke neither make explicit reference to nor are premised on the existence of an ERISA plan. Compare

Ingersoll-Rand, 111 S. Ct. at 483. Rather, applied in this case against a defendant that provides benefit-related services to an ERISA plan, the generally applicable negligence-based causes of action may have an effect on an ERISA-governed plan. In our view, the pre-emption question devolves into an assessment of the significance of these effects.

1. United's position -- it makes benefit determinations, not medical decisions

United's argument in favor of pre-emption is grounded in the notion that the decision it made concerning Mrs. Corcoran was not primarily a medical decision, but instead was a decision made in its capacity as a plan fiduciary about what benefits were authorized under the Plan. All it did, it argues, was determine whether Mrs. Corcoran qualified for the benefits provided by the plan by applying previously established eligibility criteria. The argument's coup de grace is that under well-established precedent,[12] participants may not sue in tort to redress injuries flowing from decisions about what benefits are to be paid under a plan. One commentator has endorsed this view of lawsuits against providers of utilization review services, arguing that, because medical services are the "benefits" provided by a utilization review company, complaints about the quality of medical services (i.e., lawsuits for negligence) "can therefore be characterized as claims founded upon a constructive denial of plan benefits." Chittenden, Malpractice Liability and

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[12] Pilot Life, 481 U.S. at 47-48.

Managed Health Care: History & Prognosis, 26 Tort & Ins. Law J. 451, 489 (1991).

In support of its argument, United points to its explanatory booklet and its language stating that the company advises the patient's doctor "what the medical plan will pay for, based on a review of [the patient's] clinical information and nationally accepted medical guidelines for the treatment of [the patient's] condition." It also relies on statements to the effect that the ultimate medical decisions are up to the beneficiary's doctor. It acknowledges at various points that its decision about what benefits would be paid was based on a consideration of medical information, but the thrust of the argument is that it was simply performing commonplace administrative duties akin to claims handling.

Because it was merely performing claims handling functions when it rejected Dr. Collins's request to approve Mrs. Corcoran's hospitalization, United contends, the principles of Pilot Life and its progeny squarely foreclose this lawsuit. In Pilot Life, a beneficiary sought damages under various state-law tort and contract theories from the insurance company that determined eligibility for the employer's long term disability benefit plan. The company had paid benefits for two years, but there followed a period during which the company terminated and reinstated the beneficiary several times. 481 U.S. at 43. The Court made clear, however, that ERISA pre-empts state-law tort and contract actions in which a beneficiary seeks to recover damages for

improper processing of a claim for benefits. Id. at 48-49. United suggests that its actions here were analogous to those of the insurance company in Pilot Life, and therefore urges us to apply that decision.

2. The Corcorans' position -- United makes medical decisions, not benefit determinations

The Corcorans assert that Pilot Life and its progeny are inapposite because they are not advancing a claim for improper processing of benefits. Rather, they say, they seek to recover solely for United's erroneous medical decision that Mrs. Corcoran did not require hospitalization during the last month of her pregnancy. This argument, of course, depends on viewing United's action in this case as a medical decision, and not merely an administrative determination about benefit entitlements. Accordingly, the Corcorans, pointing to the statements United makes in the QCP booklet concerning its medical expertise, contend that United exercised medical judgment which is outside the purview of ERISA pre-emption.

The Corcorans suggest that a medical negligence claim is permitted under the analytical framework we have developed for assessing pre-emption claims. Relying on Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc., 793 F.2d 1456 (5th Cir. 1986), cert. denied, 479 U.S. 1034 (1987), they contend that we should not find the state law under which they proceed pre-empted because it (1) involves the exercise of traditional state authority and (2) is a law of general application which, although it affects relations between

principal ERISA entities in this case, is not designed to affect the ERISA relationship.[13]

3. Our view -- United makes medical decisions incident to benefit determinations

We cannot fully agree with either United or the Corcorans. Ultimately, we conclude that United makes medical decisions -- indeed, United gives medical advice -- but it does so in the context of making a determination about the availability of benefits under the plan. Accordingly, we hold that the Louisiana tort action asserted by the Corcorans for the wrongful death of their child allegedly resulting from United's erroneous medical decision is pre-empted by ERISA.

Turning first to the question of the characterization of United's actions, we note that the QCP booklet and the SPD lend substantial support to the Corcorans' argument that United makes

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[13] Amicus curiae Louisiana Trial Lawyers Association (LTLA) argues that United is not an ERISA fiduciary, and that therefore the tort claims against it cannot be pre-empted. The parties, however, agree that United is a fiduciary, and we have no reason to dispute this. United's contract with Bell would appear to give it "discretionary authority or discretionary control respecting management of [the] plan" or "authority or control respecting management or disposition of its assets. . . [,]" thus satisfying the statutory definition of a fiduciary. 29 U.S.C. § 1002(21)(A)(i). In any event, all courts of appeals to have considered the issue have held that ERISA pre-emption may apply regardless of whether the defendant is a plan fiduciary. Consolidated Beef Indus., Inc. v. New York Life Ins. Co., 949 F.2d 960, 964 (8th Cir. 1991); Gibson v. Prudential Ins. Co., 915 F.2d 414, 417-18 (9th Cir. 1990); Howard v. Parisian, Inc., 807 F.2d 1560, 1564 (11th Cir. 1987). Despite the suggestion in Howard that this circuit so held in Light v. Blue Cross and Blue Shield of Alabama, 790 F.2d 1247 (5th Cir. 1986), there is no indication that the defendant in Light was not a fiduciary, and even if it was not, no part of the opinion considers the precise question whether ERISA pre-empts suits against nonfiduciaries.

medical decisions. United's own booklet tells beneficiaries that it "assess[es] the need for surgery or hospitalization and . . . determine[s] the appropriate length of stay for a hospitalization, based on nationally accepted medical guidelines." United "will discuss with your doctor the appropriateness of the treatments recommended and the availability of alternative types of treatments." Further, "United's staff includes doctors, nurses, and other medical professionals knowledgeable about the health care delivery system. Together with your doctor, they work to assure that you and your covered family members receive the most appropriate medical care." According to the SPD, United will "provid[e] you with information which will permit you (in consultation with your doctor) to evaluate alternatives to surgery and hospitalization when those alternatives are medically appropriate."

United makes much of the disclaimer that decisions about medical care are up to the beneficiary and his or her doctor. While that may be so, and while the disclaimer may support the conclusion that the relationship between United and the beneficiary is not that of doctor-patient, it does not mean that United does not make medical decisions or dispense medical advice. See Wickline, 239 Cal. Rptr. at 819 (declining to hold Medi-Cal liable but recognizing that it made a medical judgment); Macaulay, Health Care Cost Containment and Medical Malpractice: On a Collision Course, 19 Suffolk U.L. Rev. 91, 106-107 (1986) ("As illustrated in [Wickline], an adverse prospective

determination on the 'necessity' of medical treatment may involve complex medical judgment.") (footnote omitted). In response, United argues that any such medical determination or advice is made or given in the context of administering the benefits available under the Bell plan. Supporting United's position is the contract between United and Bell, which provides that "[United] shall contact the Participant's physician and based upon the medical evidence and normative data determine whether the Participant should be eligible to receive full plan benefits for the recommended hospitalization and the duration of benefits."

United argues that the decision it makes in this, the prospective context, is no different than the decision an insurer makes in the traditional retrospective context. The question in each case is "what the medical plan will pay for, based on a review of [the beneficiary's] clinical information and nationally accepted medical guidelines for the treatment of [the beneficiary's] condition." See QCP Booklet at 4. A prospective decision is, however, different in its impact on the beneficiary than a retrospective decision. In both systems, the beneficiary theoretically knows in advance what treatments the plan will pay for because coverage is spelled out in the plan documents. But in the retrospective system, a beneficiary who embarks on the course of treatment recommended by his or her physician has only a potential risk of disallowance of all or a part of the cost of that treatment, and then only after treatment has been rendered.

In contrast, in a prospective system a beneficiary may be squarely presented in advance of treatment with a statement that the insurer will not pay for the proposed course of treatment recommended by his or her doctor and the beneficiary has the potential of recovering the cost of that treatment only if he or she can prevail in a challenge to the insurer's decision. A beneficiary in the latter system would likely be far less inclined to undertake the course of treatment that the insurer has at least preliminarily rejected.

By its very nature, a system of prospective decisionmaking influences the beneficiary's choice among treatment options to a far greater degree than does the theoretical risk of disallowance of a claim facing a beneficiary in a retrospective system. Indeed, the perception among insurers that prospective determinations result in lower health care costs is premised on the likelihood that a beneficiary faced with the knowledge of specifically what the plan will and will not pay for will choose the treatment option recommended by the plan in order to avoid risking total or partial disallowance of benefits. When United makes a decision pursuant QCP, it is making a medical recommendation which -- because of the financial ramifications -- is more likely to be followed.[14]

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[14] It is the medical decisionmaking aspect of the utilization review process that has spawned the literature assessing the application of malpractice and other negligence-based doctrines to hold these entities liable for patient injuries. See Blum, supra, at 199 ("The overriding incentive for [utilization review] may be cost containment, but the process itself is triggered by a medical evaluation of a particular case,

Although we disagree with United's position that no part of its actions involves medical decisions, we cannot agree with the Corcorans that no part of United's actions involves benefit determinations. In our view, United makes medical decisions as part and parcel of its mandate to decide what benefits are available under the Bell plan. As the QCP Booklet concisely puts it, United decides "what the medical plan will pay for." When United's actions are viewed from this perspective, it becomes apparent that the Corcorans are attempting to recover for a tort allegedly committed in the course of handling a benefit determination. The nature of the benefit determination is different than the type of decision that was at issue in Pilot Life, but it is a benefit determination nonetheless. The principle of Pilot Life that ERISA pre-empts state-law claims alleging improper handling of benefit claims is broad enough to cover the cause of action asserted here.

Moreover, allowing the Corcorans' suit to go forward would contravene Congress's goals of "ensur[ing] that plans and plan sponsors would be subject to a uniform body of benefit law" and "minimiz[ing] the administrative and financial burdens of complying with conflicting directives among States or between States and the Federal Government." Ingersoll-Rand Co., 111 S.

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an evaluation that requires a clinical judgment.") (footnote omitted); Tiano, supra, at 80 ("The patient faces conflicting judgments by two medical professionals: the treating physician and the utilization review consultant"); Chittenden, supra, at 476 ("negligent implementation of cost-control mechanisms may affect the medical judgment of the physician or other provider resulting in physical injury to the patient").

Ct. at 484; see also Fort Halifax Packing, 482 U.S. at 9-10. Thus, statutes that subject plans to inconsistent regulatory schemes in different states, thereby increasing inefficiency and potentially causing the plan to respond by reducing benefit levels, are consistently held pre-empted. See Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 524 (1981) (striking down law which prohibited plans from offsetting benefits by amount of worker compensation payments); Shaw, 463 U.S. at 105 n.25 (striking down law which prohibited plans from discriminating on basis of pregnancy); FMC Corp., 111 S. Ct. at 408 (striking down law which eliminated plans' right of subrogation from claimant's tort recovery). But in Ingersoll-Rand, the Court, in holding pre-empted the Texas common law of wrongful discharge when applied against an employer who allegedly discharged an employee to avoid contributing to the employee's pension plan, made clear that a state common law cause of action is equally capable of leading to the kind of patchwork scheme of regulation Congress sought to avoid:

> It is foreseeable that state courts, exercising their common law powers, might develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. Such an outcome is fundamentally at odds with the goal of uniformity that congress sought to implement.

111 S. Ct. at 484. Similarly, although imposing liability on United might have the salutary effect of deterring poor quality

medical decisions,[15] there is a significant risk that state liability rules would be applied differently to the conduct of utilization review companies in different states. The cost of complying with varying substantive standards would increase the cost of providing utilization review services, thereby increasing the cost to health benefit plans of including cost containment features such as the Quality Care Program (or causing them to eliminate this sort of cost containment program altogether) and ultimately decreasing the pool of plan funds available to reimburse participants. See Macaulay, supra, at 105.[16]

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[15] See Comment, A Cost Containment Malpractice Defense: Implications for the Standard of Care and for Indigent Patients, 26 Hous. L. Rev. 1007, 1021 (1989) (by Leslie C. Giordani).

[16] We find Independence HMO, Inc. v. Smith, 733 F. Supp. 983 (E.D. Pa. 1990), cited by the Corcorans, distinguishable on its facts. In Smith, the district court did not find pre-empted a state court malpractice action brought against an HMO by one of its members. The plaintiff sought to hold the HMO liable, under a state-law agency theory, for the alleged negligence of a surgeon associated with the HMO. The case appears to support the Corcorans because the plaintiff was attempting to hold an ERISA entity liable for medical decisions. However, the medical decisions at issue do not appear to have been made in connection with a cost containment feature of the plan or any other aspect of the plan which implicated the management of plan assets, but were instead made by a doctor in the course of treatment.

We also find Eurine v. Wyatt Cafeterias, No. 3-91-0408-H (N.D. Tex. Aug. 21, 1991), cited in the Corcorans' reply brief, irrelevant to this case. In Eurine, an employee of Wyatt Cafeterias sued after she slipped and fell at work. Wyatt had opted out of Texas's workers' compensation scheme, but provided benefits for injured employees pursuant to an ERISA plan. The court held that a tort suit against the employer for its negligence in failing to maintain the floor in a safe condition had nothing to do with the ERISA relationship between the parties, but instead arose from their distinct employer-employee relationship.

It may be true, as the Corcorans assert, that Louisiana tort law places duties on persons who make medical judgments within the state, and the Louisiana courts may one day recognize that this duty extends to the medical decisions made by utilization review companies. But it is equally true that Congress may pre-empt state-law causes of action which seek to enforce various duties when it determines that such actions would interfere with a carefully constructed scheme of federal regulation. See Pilot Life, 481 U.S. at 48. The acknowledged absence of a remedy under ERISA's civil enforcement scheme for medical malpractice committed in connection with a plan benefit determination does not alter our conclusion. While we are not unmindful of the fact that our interpretation of the pre-emption clause leaves a gap in remedies within a statute intended to protect participants in employee benefit plans, see Shaw, 463 U.S. at 90; Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 113 (1989), the lack of an ERISA remedy does not affect a pre-emption analysis. Memorial Hosp., 904 F.2d at 248 & n.16; Lee, 894 F.2d at 757. Congress perhaps could not have predicted the interjection into the ERISA "system" of the medical utilization review process, but it enacted a pre-emption clause so broad and a statute so comprehensive that it would be incompatible with the language,

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Finally, to the extent that two other decisions cited by the Corcorans, Kohn v. Delaware Valley HMO, Inc., No. 91-2745 (E.D. Pa. Dec. 20, 1991 and Feb. 5, 1992), and Cooney v. South Central Bell Tel. Co., No. 91-3870 (E.D. La. March 5, 1992), conflict with our holding, we decline to follow them.

structure and purpose of the statute to allow tort suits against entities so integrally connected with a plan.

We are not persuaded that Sommers Drug, on which the Corcorans rely heavily, commands a different outcome. In Sommers Drug, we observed that courts are less likely to find pre-emption when the state law involves an exercise of traditional state authority than when the law affects an area not traditionally regulated by the states. Id. at 1467. The Corcorans contend that they easily pass this hurdle, as tort law traditionally has been reserved to the states, but this victory only puts them back at the starting line again. We went on to say in Sommers Drug that we were "not convinced" that the traditional or nontraditional nature of the state law properly bears upon the initial question whether it is pre-empted by § 514(a), because the distinction had no support in the statutory language. Id. at 1468. We continue to adhere to this view. As cases such as Ingersoll-Rand and Christopher illustrate, the fact that states traditionally have regulated in a particular area has functioned as no impediment to ERISA pre-emption. See Ingersoll-Rand, 111 S. Ct. at 483 (wrongful discharge action pre-empted); Christopher, 950 F.2d at 1218 (fraud action pre-empted). ERISA's pre-emption section itself contains an explicit exemption for state laws that regulate in at least one area of traditional state function -- insurance. ERISA § 514(b)(2)(A). There is no reason to believe that Congress intended implicitly to exempt a

whole range of state laws when it showed itself perfectly capable of carving out specific exemptions.

The second factor identified in Sommers Drug as bearing on pre-emption -- whether the state law affects relations among principal ERISA entities -- continues to be relevant in this circuit, see Memorial Hospital Systems v. Northbrook Life Insurance Co., 904 F.2d 236, 245, 248-50 (5th Cir. 1990), but it does not help the Corcorans. In the case before us, of course, the cause of action affects relations between principal ERISA entities. Nevertheless, the Corcorans argue, Sommers Drug holds that the claim will not be pre-empted where the state law is one of general application and it does not affect relations among the principal ERISA entities "as such," but in their capacities as entities in another kind of relationship. They analogize to Sommers Drug, where we held that a pension plan, acting in its "non-ERISA" capacity as a shareholder in a company, could invoke the state common law of corporate fiduciary duty against an officer and director of the company and a plan fiduciary to redress an alleged breach of fiduciary duty. 793 F.2d at 1468-70. The short answer to this argument is that the cause of action in this case is not between parties acting in the kind of non-ERISA context we found in Sommers Drug. Although the claims in Sommers Drug nominally affected relations between ERISA entities, the lawsuit had nothing to do with the plan. Here, however, the central purpose of the lawsuit is to hold United liable for actions it took in connection with its duties under

the plan. Sommers Drug does not mitigate the pre-emptive force of ERISA § 514(a).

IV. EXTRACONTRACTUAL DAMAGES

The Corcorans argue in the alternative that the damages they seek are available as "other appropriate equitable relief" under ERISA § 502(a)(3). That section provides:

> (a) A civil action may be brought --
>
> . . .
>
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;
> . . .

Although the Corcorans did not assert a cause of action under § 502(a)(3) in their original state court complaint, they asked the district court in their motion for reconsideration to award damages pursuant to this section. The defendants agreed at oral argument that the issue was properly raised and preserved for appeal, and we proceed to consider it.

Section 502(a)(3) provides for relief apart from an award of benefits due under the terms of a plan. When a beneficiary simply wants what was supposed to have been distributed under the plan, the appropriate remedy is § 502(a)(1)(B). See, e.g., Cathey v. Dow Chemical Co. Medical Care Program, 907 F.2d 554, 555 (5th Cir. 1990), cert. denied, 111 S. Ct. 964 (1991). Damages that would give a beneficiary more than he or she is

entitled to receive under the strict terms of the plan are typically termed "extracontractual." Section 502(a)(3) by its terms permits beneficiaries to obtain "other appropriate equitable relief" to redress (1) a violation of the substantive provisions of ERISA or (2) a violation of the terms of the plan. Although the Corcorans have neither identified which of these two types of violations they seek to redress nor directed us to the particular section of the Plan or ERISA which they claim was violated, we need not determine this in order to resolve the issue before us. As outlined below, we find that the particular damages the Corcorans seek -- money for emotional injuries -- would not be an available form of damages under the trust and contract law principles which, the Corcorans urge, should guide our interpretation of ERISA's remedial scheme. Thus, we hold that even under the interpretation of § 502(a)(3) urged by the Corcorans, they may not recover.

The question whether extracontractual or punitive damages are available to a beneficiary under § 502(a)(3) has been left open by the Supreme Court ever since Massachusetts Mutual Life Insurance Co. v. Russell, 473 U.S. 134 (1985). In Russell, the beneficiary of a plan sought compensatory and punitive damages under ERISA §§ 502(a)(2) and 409(a)[17] for the improper processing of her claim for disability benefits. Id. at 136, 138. The Court rejected the argument that such damages were

[17] Section 502(a)(2) permits "the Secretary. . .a participant, beneficiary or fiduciary" to sue for appropriate relief under § 409.

available under § 409(a), holding that § 409(a) (1) authorized only actions on behalf of the plan as a whole, not individual beneficiaries, for losses to the plan; and (2) provided no implied cause of action for extracontractual damages caused by improper claims processing. Russell, 473 U.S. at 140, 147. Because the beneficiary expressly disclaimed reliance on § 502(a)(3), however, the Court had no occasion to consider whether the damages the plaintiff sought were available under that section. Id. at 139 n.5.

In a concurrence joined by three other Justices, Justice Brennan emphasized that he read the Court's reasoning to apply only to § 409(a), and that the legislative history of ERISA suggested that courts should develop a federal common law in fashioning "other appropriate equitable relief" under § 502(a)(3). Id. at 155-56 (Brennan, J., concurring in the judgment). Justice Brennan argued that Congress "intended to engraft trust-law principles onto the enforcement scheme" of ERISA, including the principle that courts should give to beneficiaries of a trust the remedies necessary for the protection of their interests. Id. at 156-57. Consequently, he encouraged courts faced with claims for extracontractual damages first to determine to what extent state and federal trust and pension law provide for the recovery of damages beyond any benefits that have been withheld, and second to consider whether extracontractual relief would conflict with ERISA in any way. Id. at 157-58. With respect to the first inquiry he indicated

that any deficiency in trust law in the availability of make-whole remedies should not deter courts from authorizing such remedies under § 502(a)(3), for Congress intended in ERISA to strengthen the requirements of the common law of trusts as they relate to employee benefit plans. Id. at 157 n.17. Finally, Justice Brennan suggested, courts should keep in mind that the purpose of ERISA is the "enforcement of strict fiduciary standards of care in the administration of all aspects of pension plans and promotion of the best interests of participants and beneficiaries." Id. at 158.

The Corcorans urge us to apply Justice Brennan's concurrence and hold that the damages they seek amount to "other appropriate equitable relief." The defendants, on the other hand, urge us to interpret "other appropriate equitable relief" to include only declaratory and injunctive relief. Under the defendants' view of § 502(a)(3), which has been adopted by a number of circuits,[18] no money damages would be awardable and our discussion would be at an end. However, even assuming that Justice Brennan's view of "other appropriate equitable relief" as potentially encompassing make-whole relief is a proper construction of that section, the damages the Corcorans seek would not be available.

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[18] Drinkwater v. Metropolitan Life Ins. Co., 846 F.2d 821 (1st Cir.), cert. denied, 488 U.S. 909 (1988); Harsch v. Eisenberg, 956 F.2d 651 (7th Cir. 1992), petition for cert. filed, 60 U.S.L.W. 3816 (U.S. May 11, 1992) (No. 91-1835); Novak v. Andersen Corp., No. 91-1957 (8th Cir. April 9, 1992); Sokol v. Bernstein, 803 F.2d 532 (9th Cir. 1986); Bishop v. Osborn Transp., Inc., 838 F.2d 1173 (11th Cir.), cert. denied, 488 U.S. 832 (1988).

The characterization of equitable relief as encompassing damages necessary to make the plaintiff whole may well be consistent with the trust law principles that were incorporated into ERISA and which guide its interpretation. See Firestone, 489 U.S. at 110-11 (because ERISA is largely based on trust law, those principles guide interpretation); H.R. Rep. No. 533, 93d Cong., 1st Sess. (1973), reprinted in 1974 U.S. Code Cong. & Admin. News 4639; S. Rep. No. 127, 93d Cong., 1st Sess., reprinted in 1974 U.S. Code Cong. & Admin. News 4838 (indicating intent to incorporate the law of trusts into ERISA). Section 205 of the Restatement (Second) of Trusts allows for monetary damages as make-whole relief, providing that a beneficiary has "the option of pursuing a remedy which will put him in the position in which he was before the trustee committed the breach of trust" or "of pursuing a remedy which will put him in the position in which he would have been if the trustee had not committed the breach of trust." In the context of the breach of a trustee's investment duties, "the general rule [is] that the object of damages is to make the injured party whole, that is, to put him in the same condition in which he would have been if the wrong had not been committed. . . . Both direct and consequential damages may be awarded." G. Bogert & G. Bogert, The Law of Trusts and Trustees § 701, at 198 (2d ed. 1982). See also Estate of Talbot, 141 Cal. App. 309, 296 P.2d 848 (1956); In re Cook's Will, 136 N.J. Eq. 123, 40 A.2d 805 (1945).

This view may also be consistent with the common law contract doctrine which assists us in interpreting ERISA. As the Court observed in Russell, ERISA was enacted "to protect contractually defined benefits." 473 U.S. at 148. Prior to the enactment of ERISA, the rights and obligations of pension beneficiaries and trustees were governed not only by trust principles, but in large part by contract law. Firestone, 489 U.S. at 112-13; see also Rochester Corp. v. Rochester, 450 F.2d 118, 120-21 (4th Cir. 1971); Audio Fidelity Corp. v. Pension Benefit Guaranty Corp., 624 F.2d 513, 517 (4th Cir. 1980); Hoefel v. Atlas Tack Corp., 581 F.2d 1, 4-7 (1st Cir. 1978). It is well-established that contract law enables an aggrieved party to recover such damages as would place him in the position he would have occupied had the contract been performed, Restatement (Second) of Contracts § 347 & comment a (1981), including those damages that could reasonably have been foreseen to flow from the breach. Id. § 351; see Warren v. Society Nat. Bank, 905 F.2d 975, 980 (6th Cir. 1990) (§ 502(a)(3) allows for recovery of beneficiaries' increased tax liability after plan administrators failed to follow instructions regarding distribution), cert. denied, 111 S. Ct. 2556 (1991).

However, the Corcorans seek a form of extracontractual damages that is never, as far as we can tell, awarded for breach of trust duties, and is granted only in the most limited of circumstances for a breach of contract. Certainly, patients and their physicians can enter into contracts and physicians may

incur liability for breach. The cases are uniform, however, in holding that there can be no recovery against a physician on a contractual theory, as opposed to the usual recovery on a tort theory of medical negligence, unless there is an express agreement to perform a particular service or to achieve a specific cure. E.g., Bobrick v. Bravstein, 497 N.Y.S.2d 749, 751, 116 A.D.2d 682 (App. Div. 1986); Cirafici v. Goffen, 85 Ill. App. 3d 1102, 407 N.E.2d 633, 635, 41 Ill. Dec. 135 (1980); Depenbrok v. Kaiser Foundation Health Plan, Inc., 79 Cal. App. 3d 167, 144 Cal. Rptr. 724, 726 (1978). In a few cases, courts, recognizing a distinction between commercial contracts and contracts for the performance of personal services, have found inapplicable the general rule that emotional distress damages are not available in contract actions[19] and have allowed damages for emotional injuries within the contemplation of the parties. Stewart v. Rudner, 349 Mich. 459, 84 N.W.2d 816, 824 (1957) ("the parties may reasonably be said to have contracted with reference to the payment of [emotional distress] damages therefor in event of breach"); Sullivan v. O'Connor, 363 Mass. 579, 296 N.E.2d 183, 188-89 (1973) (although mental anguish damages are not available for breach of a commercial contract, psychological injury may be contemplated in a contract for an operation) (citing Stewart). The Stewart rule, however, has not been widely adopted, and the

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[19] See J. Calamari & J. Perillo, The Law of Contracts §§ 14-3, 14-5(b), at 595-96 (3d ed. 1987); 11 W. Jaeger, Williston on Contracts § 1341, at 214 (3d ed. 1968); 5 Corbin on Contracts § 1076, at 426 (2d ed. 1964).

Michigan courts recently have characterized its holding concerning damages as applying only to contracts involving deep, personal relationships, Chrum v. Charles Heating & Cooling, Inc., 121 Mich. App. 17, 327 N.W.2d 568, 570 (1982), and contracts to perform very specific acts. Penner v. Seaway Hosp., 169 Mich. App. 502, 427 N.W.2d 584, 587 (1988).

The strictness with which courts have viewed doctor-patient contracts thwarts the Corcorans' claim that emotional distress damages would be available here under a make-whole interpretation of § 502(a)(3). The existence of a true doctor-patient relationship between Mrs. Corcoran and United which could support a contractual theory of recovery is dubious at best. Related to this problem is the lack of an express agreement for a particular service or for a particular result that serves as a prerequisite to a contract-based recovery. Even assuming that United's booklet could be considered an aspect of the "plan," breach of which would give rise to a cause of action under § 502(a)(3), it cannot be construed as making an agreement to perform any particular medical procedure or to arrive at any result. At most it makes promises to act in accordance with accepted standards of medical care. But courts have not recognized these sorts of promises as creating contractual duties between physicians and patients. Cirafici, 407 N.E.2d at 635-36 (failure to perform with requisite skill and care leads to action for negligence, not breach of contract); Awkerman v. Tri-County Orthopedic Group, P.C., 143 Mich. App. 722, 373 N.W.2d 204, 206 (1985) (physician's

breach of express or implied promise to act in accordance with standard of care not actionable in contract). Indeed, the Massachusetts Supreme Judicial Court has emphasized that in an action seeking damages under Sullivan, one of the leading cases allowing mental distress damages for a breached medical contract, recovery is not for the doctor's failure to live up to the standard of care but solely for a failure to perform the specific promise contained in the agreement. Salem Orthopedic Surgeons, Inc. v. Quinn, 377 Mass. 514, 386 N.E.2d 1268, 1271 (1979). See also Murray v. University of Pennsylvania Hosp., 490 A.2d 839, 841 (Pa. Super. 1985) (action for breach of contract to achieve particular result may lie even if doctor has exercised highest degree of skill and care).

The fact that courts regularly view doctors and their patients as standing in a fiduciary relationship, e.g., Black v. Littlejohn, 312 N.C. 626, 325 S.E.2d 469, 482 (1985); Liebergesell v. Evans, 93 Wash. 2d 881, 613 P.2d 1170, 1176 (1980); State ex rel. Stufflebaum v. Appelquist, 694 S.W.2d 882, 885 (Mo. App. 1985), also is of no avail. Although a plan beneficiary certainly may sue under § 502(a)(3) for a breach of the fiduciary duties set forth in § 404, the lack of a true doctor-patient relationship between Mrs. Corcoran and United undermines this ground of recovery. In any event, courts have not held that patients may sue their doctors under any independent "breach of fiduciary duty" theory. The remedies are limited to contract actions (where an express agreement has been

made) and, in the vast majority of cases, tort actions for negligence. Assuming without deciding, therefore, that § 502(a)(3) permits the award of make-whole relief as "other appropriate equitable relief," we hold that the emotional distress and mental anguish damages sought here by the Corcorans are not recoverable.

* * *

The result ERISA compels us to reach means that the Corcorans have no remedy, state or federal, for what may have been a serious mistake. This is troubling for several reasons. First, it eliminates an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system. With liability rules generally inapplicable, there is theoretically less deterrence of substandard medical decisionmaking. Moreover, if the cost of compliance with a standard of care (reflected either in the cost of prevention or the cost of paying judgments) need not be factored into utilization review companies' cost of doing business, bad medical judgments will end up being cost-free to the plans that rely on these companies to contain medical costs.[20] ERISA plans, in

[20] We note that, were the Corcorans able to recover against United under state law, the contract between Bell and United indicates that United would bear the cost. However, the general application of a liability system to utilization review companies would ultimately result in increased costs to plans such as the Bell plan as it became more expensive for companies such as United to do business.

we acknowledge our role today by interpreting ERISA in a manner consistent with the expressed intentions of its creators.

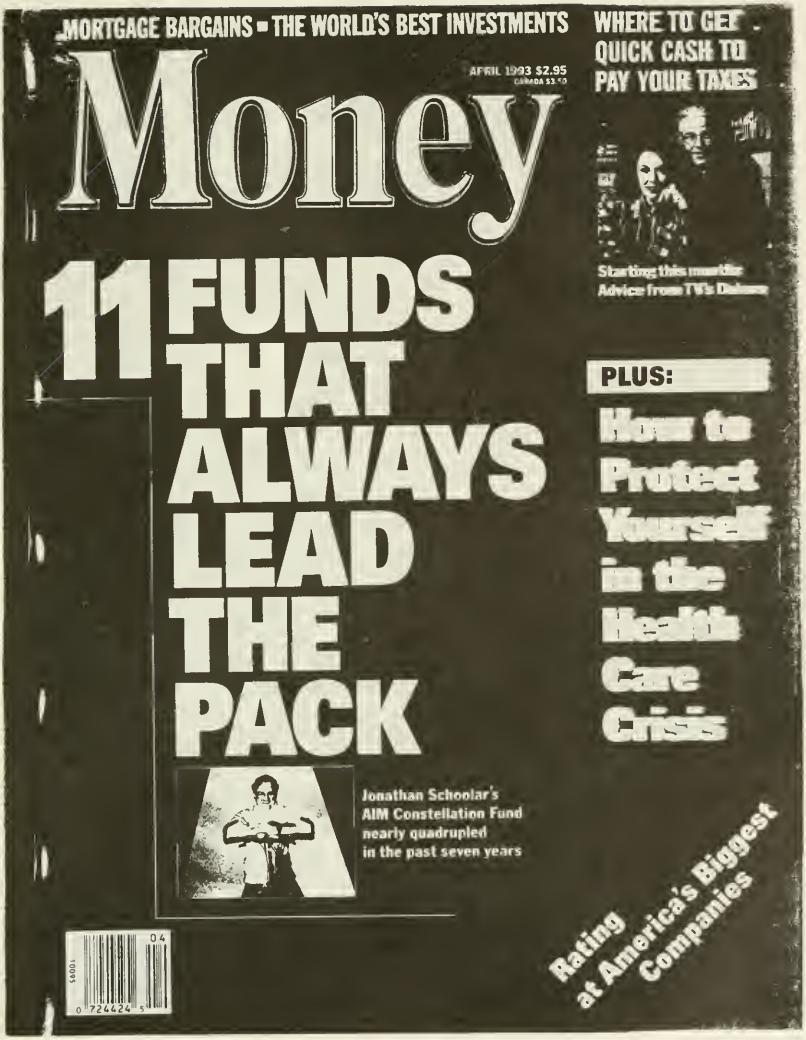
V. CONCLUSION

For all the foregoing reasons, we find that ERISA pre-empts the Corcorans' tort claim against United and that the Corcorans may not recover damages for emotional distress under § 502(a)(3) of ERISA. Accordingly, the judgment of the district court is AFFIRMED.

turn, will have one less incentive to seek out the companies that can deliver both high quality services and reasonable prices.

Second, in any plan benefit determination, there is always some tension between the interest of the beneficiary in obtaining quality medical care and the interest of the plan in preserving the pool of funds available to compensate all beneficiaries. In a prospective review context, with its greatly increased ability to deter the beneficiary (correctly or not) from embarking on a course of treatment recommended by the beneficiary's physician, the tension between interest of the beneficiary and that of the plan is exacerbated. A system which would compensate the beneficiary who changes course based upon a wrong call for the costs of that call might ease the tension between the conflicting interests of the beneficiary and the plan.

Finally, cost containment features such as the one at issue in this case did not exist when Congress passed ERISA. While we are confident that the result we have reached is faithful to Congress's intent neither to allow state-law causes of action that relate to employee benefit plans nor to provide beneficiaries in the Corcorans' position with a remedy under ERISA, the world of employee benefit plans has hardly remained static since 1974. Fundamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA so that it can continue to serve its noble purpose of safeguarding the interests of employees. Our system, of course, allocates this task to Congress, not the courts, and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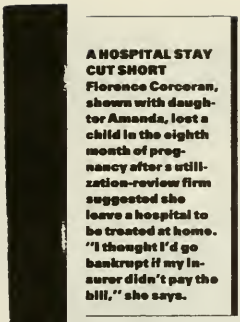
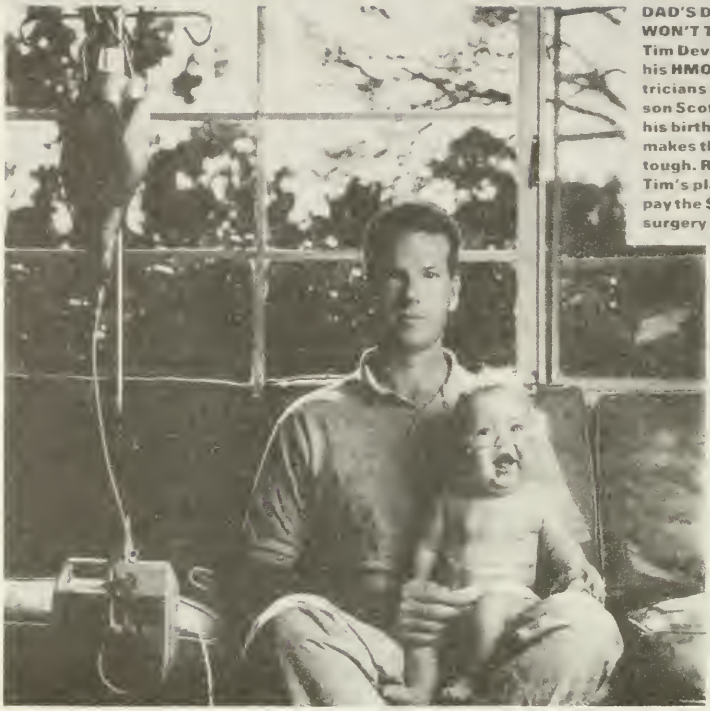


A HOSPITAL STAY CUT SHORT Florence Corcoran, shown with daughter Amanda, lost a child in the eighth month of pregnancy after a utilization-review firm suggested she leave a hospital to be treated at home. "I thought I'd go bankrupt if my insurer didn't pay the bill," she says.

While Hillary Clinton won't announce her R$_x$ for the nation's health-care ills until May, chances are you've already tasted one of the likely medicines—and perhaps suffered its ill effects.

That drug is managed care, a style of delivering health care that is often praised as the best hope for curbing medical price inflation. Though President Clinton hasn't formally endorsed it, he has backed a reform scheme called managed competition that would bring managed care in its wake. Even if Clinton does an about-face, though, managed care is here to stay: Insurers and company health plans have already stampeded into programs like utilization review, health maintenance organizations (HMOs), preferred-provider organizations (PPOs) and point-of-service plans (POSs), all of which aim to shave costs by managing care. (For definitions, see page 122.)

While these arrangements differ in detail, they share this: Treatment decisions are no longer up to you and your doctor alone. Instead, your choice of treatment is subject to approval by others whose mission is to curtail



DAD'S DOCTORS WON'T TAKE HIM Tim Devine says his HMO's pediatricians won't treat son Scott because his birth defect makes the case too tough. Result: Tim's plan won't pay the $750,000 surgery bill.

Managed care brings minimal savings and may impair the quality of treatment.

costs. Often, your choice of doctor or hospital is limited too.

Proponents argue that this is the best way to slow medicine's insane price spiral. But in three months of talking with patients, doctors, lawyers, administrators and policy experts, MONEY found that managed care—as currently practiced—can cause problems as thorny as those it's meant to solve. In particular:

- A small but growing body of evidence suggests that managed care is no magic bullet for escalating costs, at least not over the long run.
- On the contrary, it may sometimes raise expenses by adding bureaucracy to an already bloated system.
- This bureaucracy sets up obstacles for doctors and patients that are aggravating at best and that sometimes interfere with needed treatment.
- In plans that encourage the use of a limited circle of physicians, the sickest patients may get the worst care.

Bottom line: Managed care buys us little in the way of savings but may cost us much in terms of quality of care—occasionally with tragic results.

These problems of managed care do not mean there should be no limits placed on medical treatment. Nearly everyone agrees that the traditional system of fee-for-service health insurance needs reform, including 72% of MONEY readers in our recent poll (see page 29). After all, the current system allowed health costs to zoom up by an average of 11.7% a year since 1973, nearly double the 6.2% pace of inflation, to $940 billion this year—one dollar in every seven we spend—while leaving 37 million Americans devoid of any coverage.

Yet managed care is not the only possible solution. In Canada, for ex-

ample, where doctors and patients have great autonomy in choosing treatments, per capita expenditures are 30% less than in the U.S. One reason: The Canadian government, which insures all citizens, negotiates prices with doctors and hospitals.

Canada's costs are climbing too, of course, and there are drawbacks like delays in getting some elective treatment. So Americans may well conclude that managed care is the right medicine. Indeed, 93% of all health plans already employ utilization review, and the more restrictive forms of managed care are growing rapidly: The percentage of insured people covered by HMOs, PPOs or POSs rose from 27% in 1987 to 49% last year. As Michael Herbert, chairman of the American Managed Care and Review Association, a trade group, puts it: "People better get used to managed care because, in a few years, that may be all there is." For advice on how you can get the most out of the system, see the next page.

The goal of managed care is to excise the estimated 20% to 30% of treatment that may be ineffective or unneeded. Utilization-review companies try to do this by requiring patients to notify them upon entering a hospital. If the review firm disapproves of the hospital stay, the patient can appeal. But if the appeal is denied, the patient pays the bill.

HMOs, PPOs and POSs practice a more comprehensive cost control: The employer—or sometimes the patient—pays a flat or discounted fee for care from a network of doctors and hospitals. Nonemergency treatment outside the network is only partially covered, or not covered at all, unless the network approves it. While treatment decisions are nominally up to doctor and patient, the network can overrule them. And the network often has an incentive to hold down costs, since that builds profits.

Supporters and critics of managed care agree the system usually brings cost savings when it is first implemented. A Congressional Budget Office review of the research literature, for example, concluded that HMOs that pay doctors a flat salary or a flat rate per patient provide care for 15% less than traditional insurance does.

Employees get a break too, often paying no deductible and fees of just $5 to $15 per doctor visit—including preventive care—vs. hundreds of dollars in deductibles and co-payments with traditional insurance.

SOME DELAYS CAN BE FATAL Mary Kuhl holds a picture of her late husband Buddy. He died after being unable to get special surgery for his heart condition, in large part because of bureaucratic snags at his HMO.

Learn to live with managed care; soon it may be all there is.

The evidence is mixed, however, on whether managed care can hold down the rate of price escalation once the system is in place. Some studies say it can: A recent survey of 2,448 companies by Foster Higgins, for example, found prices at HMOs, PPOs and POSs rose by 10.5% or less from 1991 to 1992, while those of traditional insurance plans rose 14.2%. The CBO report, however, found "little evidence, to date, that growth in spending is affected by managed care." And when the accounting firm KPMG/Peat Marwick analyzed six years of data from more than 1,000 companies, it found HMO prices rising at 11.3% annually, on average—only marginally better than the 12.7% increase for traditional insurance. "You see initial savings with managed care," says the study's director Jon Gabel, "but after that, prices rise as rapidly as at fee-for-service plans—largely because they are driven by other factors, like expensive new technology."

Some managed-care plans wind up costing more than traditional insurance, as the Foster Higgins survey showed. About 30% of employers said their HMOs were more expensive than their fee-for-service plans—perhaps because those HMOs reimburse doctors on a fee-for-service basis, which doesn't encourage economy, says the firm's John Erb.

Whatever the cause, customers of managed-care plans are watching their out-of-pocket expenses begin to inch up. The proportion of HMOs that charge $10 or more per doctor visit

HOW TO MAKE MANAGED CARE WORK FOR YOU

...for-service plans sometimes give doctors an incentive to ...nt than is necessary, many managed-care plans actually ...to *undertreat* you—since it maximizes their profits. Here are ...ways to make sure you and your family get the best care:

...PARE THOROUGHLY. When you are choosing between plans, start by reading the booklet that describes details of the plan's coverage. Check out the ...ment in order to estimate your likely out-of-pocket costs. But also ...out whether the plan will treat any pre-existing conditions you may have ...will do so, but other types of plans may not) and whether it will ...preventive health care and "experimental" treatments such as ...t. If the plan relies on a network of physicians, ask ...ists on staff you need and what restrictions it places ...are outside the network. Mike Doyle of Champaign ...Consumers, a consumer's group in Champaign, Ill., sug... the plan and ask how many primary-care physicians and ...are on its staff. The numbers should be roughly equal, ...a good balance between basic and specialized medical care.

...E, OR GET YOURS TO JOIN. If the plan relies on a limited group ...get the names of three doctors from the network's enrollee ser...ve or from friends who are plan members. Then visit each of ...at an HMO: $5 to $15 per visit). Choose one with whom ...t. Or, if you would prefer to keep seeing a non-network physi...ady treating you, ask him or her to join the plan (the doctor can ...the requirements by calling the plan's chief of medical staff). If your ...is reluctant to join and you will be reimbursed at a lower rate if you con..., ask him to share the loss by reducing his fee.

...CARE YOU NEED. Many patients complain that they have ...their plans to perform costly tests, for example. If you can't get ...procedure, ask the plan for a second opinion or a new doctor.

...SION YOU DISAGREE WITH. A study by the General Accounting Of... found that fewer than 12% of people denied coverage by utiliza... companies appeal but that more than one-third of those who do ...have their requests granted. The appeals procedure will be spelled out ...your coverage booklet. If you are refused a treatment and can afford the de..., ask the plan for a written explanation of its refusal so you can rebut it. And ...careful records, including copies of all correspondence and a phone log ...the date, the name of the person you spoke to and what was said.

...W BY A "SPECIALTY-MATCHED PHYSICIAN ADVISER," if your appeal ...proposed treatment by a specialist. That way, if you're seeking per... to see an orthopedic surgeon for a diagnostic knee procedure, you ...have that another orthopedic surgeon will judge the case ...

...ANYONE WHO WILL GIVE IT. Even in an HMO, where the doctor ...plan instead of for you, he or she is your most important ally. Ask ...doctor to explain clearly to the plan why the recommended treatment is ...and to provide paperwork, studies or records to support your case. If ...a hospital, you can seek the same help from the managed-care de... patient advocate, social worker or case manager. Don't neglect ...another, if yours is a company-paid plan, since the company will ...advocate on your behalf. "We get a number of noes changed to ...," says Miriam Gebhardt, director of human resources at Jacobs Engi... Group in Pasadena, which instituted a PPO in 1989.

...IT'S WORTH A FIGHT ABOUT IT LATER, if you feel your health is threat... Appealing a managed-care decision typically takes 30 days. If you lose, ...persuade your doctor or hospital to lower the bill. —R.S.

rose from 23% in 1991 to 29% last year, for example.

Backers of managed care say the system would contain costs better if only more people were enrolled in it. "Managed care doesn't hold costs down in the long run because it doesn't need to," says Deborah Chollet of Georgia State University. "At present, all it needs to attract business is to set prices a few dollars lower than those of traditional plans."

But critics counter that extending managed care's reach could actually undermine its advantage for two reasons. First, traditional plans suffer from a phenomenon known as adverse selection: They attract older, chronically ill patients who need more care and have longstanding relationships with doctors who aren't in managed-care networks. If managed care took on those high-cost patients, they say, its expenses would go up.

Second, when managed care and traditional plans exist side by side, doctors and hospitals who accept lower fees for managed-care patients may make up the difference by charging everyone else more. At first glance, it would seem that bringing all patients under managed care would end this practice. In fact, though, doctors can find other ways to prop up their incomes. At Southern California Edison, managed care cut annual health-cost increases from 18% a year to only about 9% a year when first introduced in '89. But the firm expects price hikes to return to 15% or so within five years, since some doctors seem to be encouraging employees to see them more often so as to make up for low fees. "Providers find the loopholes," says Barbara Decker, manager of health-care planning.

Managed care also creates an additional layer of bureaucracy. The Mayo Clinic in Rochester, Minn., for example, has hired 70 people to answer questions from cost-control groups. The annual cost of $3 million is ultimately passed along to patients. Individual physicians complain too: "It takes massive paperwork to get permission to do what patients need," says Dr. Sidney Marchasin, a Redwood City, Calif. internist. "I've had to double my staff to four people to handle it."

In addition, the main weapon of

managed care—encouraging fewer and shorter stays in the hospital—may be less potent than it appears. Thanks to changes in practice patterns, like the growth of outpatient surgery, hospital admissions have been dropping anyway: They fell by 17% at community hospitals between 1980 and 1990 for all types of plans. And those savings can be offset by increased spending elsewhere, like for nursing care or physical rehabilitation at home. Meanwhile, other costs keep rising: At Sisters of Providence Health Systems, for instance, which runs an HMO and a PPO in Portland, Ore., the average stay for hip-replacement patients fell from 11.7 days in 1988 to just 6.1 days last year. Yet the cost climbed 24% owing to price hikes for operating rooms, drugs and implants.

OF MANAGED-CARE TERMS

... The most restrictive ... care, an HMO charges em... per-patient fee that covers all ... HMO doctors (patients may pay an... to $15 a visit) and from outside doc... patients are referred by the ... Doctors in staff model HMOs practice ... hospital or clinic; in other HMOs, they ... often work in private offices.

... A group of physicians ... that agrees with employers to ... fee-for-service. Patients ... reimbursement for treat... is 50% to 70% outside. ... charges employers a flat ... within the system (patients pay ...) but reimburses patients for ... to 80% of the cost of outside care.

... A process in which an independent ... approves in advance certain treat... decisions before the insurer will agree ... for them.

Managed-care firms argue that, since they target only "wasteful" spending, they do not imperil the quality of care. Case in point: At Baystate Medical Center in Springfield, Mass., managed-care patients leave the intensive-care unit two days earlier and the hospital five days sooner than other patients do, yet are no more likely to die or to be readmitted later, according to a study in the *Archives of Internal Medicine*.

But patients and doctors complain that managed care sometimes forces them into risky compromises. Take the case of Florence Corcoran (pictured on page 114), who in 1989 developed a condition known as preeclampsia during pregnancy. Her physician put her in the hospital, but her insurer's utilization-review firm raised an eyebrow at the expected $29,400 cost. The firm—United Healthcare of Baltimore—suggested she receive 10 hours a day of at-home nursing instead, which would cost just $10,500. Corcoran went home. Two weeks later, while the nurse was off duty, the preeclampsia apparently blocked oxygen flow to the unborn baby and he died.

Like all managed-care companies, United Healthcare offers patients the right to appeal decisions they don't like, and neither Corcoran nor her doctor appealed. Says the physician, Dr. Jason Collins: "I thought my alternatives were to send her home with a nurse or with nothing at all." But Dr. Frederick Zuspan, editor-in-chief of the *American Journal of Obstetrics and Gynecology*, says review companies frequently try to send women with preeclampsia home—though the standard treatment is bed rest and fetal monitoring, usually in a hospital. Patients and doctors who defy an insurer risk not getting paid, a powerful incentive for caving in.

The appeals process itself can be daunting, as Paul Stecklair, 39, of La Mesa, Calif. found when he ruptured a disk two years ago. His PPO doctor told him to see a surgeon immediately. But one PPO surgeon was out of town and a second couldn't see him for 10 days, so the doctor sent Stecklair to a non-network surgeon who operated three days later. The insurer later overruled the doctor and refused to pay more than half of the $10,500 bill. It took a year of bickering to get the company to pay the full amount of its coverage—$9,200. A PPO spokesman explains the company's reluctance by saying that the three-day wait suggested Stecklair's

surgery was not a "here-and-now emergency." Stecklair replies: "I was in terrible pain, and if your doctor says see a surgeon immediately, you figure it's an emergency."

Sometimes the hassles involved in getting out-of-network treatment can be life threatening. When Buddy Kuhl, a manager for a Kansas City, Mo. trucking company, suffered a heart attack in April 1989, his cardiologist recommended a special surgery that had been pioneered at Barnes Hospital in St. Louis. Lincoln National, which runs the HMO, wanted the operation done in its network. But a second cardiologist consulted at the HMO's request advised Kuhl also to go to Barnes, so Kuhl scheduled an operation for July 6. Lincoln National demanded a third opinion, though, and arranged it for that same day. After the third cardiologist endorsed the idea of going to St. Louis, the company finally relented on July 20. By that time, though, the operation had to be delayed until September because the St. Louis surgeons would be away. And by September, Kuhl's heart was too weak to survive the operation. He died after collapsing in his wife's arms on Dec. 28. (Lincoln National has declined comment because the dispute is pending in court.)

Critics of managed care argue that cases like Kuhl's demonstrate an unavoidable weakness of plans that rely on a limited list of doctors: Medical care has become so diverse that it's impossible for any one HMO or PPO to include all specialties—with the result that it is sometimes the sickest patients who get the worst care.

Tim Devine and his wife Jana of Santa Barbara may be victims of this problem. They say none of the pediatricians in Tim's HMO would agree to be the principal doctor for their year-old son Scott, who was born with a severe diaphragmatic hernia, because his care would be so complex and time consuming. As a result, Blue Cross of California, which pays bills for the HMO, refused to pick up any of the estimated $750,000 cost of the nine operations Scott has had so far; no HMO physician had recommended them. (Jana's traditional health insurance has been paying the bills instead—even though Tim's HMO was

primary insurer.) Neither the HMO nor Blue Cross would comment, although Blue Cross did appoint its own physician to the case in January.

Owing to a quirk of federal law, moreover, people wronged by such plans often have limited recourse. That's because almost all employer-paid health plans fall under the federal Employee Retirement and Income Security Act (ERISA), which allows workers to sue for lost benefits but not damages. "Several courts have ruled that if someone dies because the HMO won't do surgery, all you can do is sue for the surgery itself," says C.W. Crumpecker, Mary Kuhl's attorney. "But you can't get that benefit because the patient is dead." In fact, the Fifth U.S. Circuit Court of Appeals, in throwing out Florence Corcoran's complaint because of ERISA, called on Congress to reevaluate the law because "bad medical judgments will end up being cost-free to the plans that rely on [utilization review] companies to contain medical costs."

Problems like this notwithstanding, managed care will obviously be with us for a while. Here are suggestions for correcting a few of its flaws:

- Managed-care firms should end micromanagement of individual cases and concentrate instead on setting rational guidelines for care. Only doctors who routinely go beyond those guidelines should be policed closely.
- Companies should simplify the appeals process, especially for desperately ill patients.
- Plans should be paid a flat rate per patient, rather than a fee for each visit or procedure, so as to encourage economy. But they should get more for patients whose age or illness makes them need more care. "That would reduce the incentive to undertreat or turn away sicker people," says Hal Luft of the University of California at San Francisco.
- Plans should put more emphasis on quality by, say, rewarding doctors not only for holding costs down but also for keeping patients satisfied.
- Finally, the patients or employers who pay the bills should get a greater cut of any cost savings, perhaps through a year-end rebate.

Without these changes, critics say, managed care is one cost-busting reform that we just can't afford. $

OVERSIGHT HEARING ON THE ADMINISTRATION'S HEALTH CARE PROPOSAL

TUESDAY, OCTOBER 26, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON LABOR-MANAGEMENT RELATIONS,
COMMITTEE ON EDUCATION AND LABOR,
Washington, DC.

The subcommittee met, pursuant to call, at 10 a.m., Room 2175, Rayburn House Office Building, Hon. Pat Williams, Chairman, presiding.

Members present: Representatives Williams, Martinez, Unsoeld, Klink, Becerra, Woolsey, Roukema, Gunderson, Boehner, Fawell, Ballenger, and Hoekstra.

Staff present: Jon Weintraub, staff director; Phyllis Borzi, counsel for employee benefits; Gail Brown-Hubb, staff assistant; Russ Mueller, actuary/professional staff member; and Patrick Beers, staff assistant.

Chairman WILLIAMS. Good morning. This morning the subcommittee will focus on the role of States in health care reform.

Just a few months ago the subcommittee held a hearing on the effect of the ERISA preemption on State health care reform efforts. The State officials described the limitations that ERISA placed on their ability to tailor solutions to specific problems facing their citizens.

At that time, several States, including New York and Minnesota, Hawaii, Maryland, and Oregon, were actively seeking legislation exempting provisions of their law from the ERISA preemption clause. Some representatives of the business community, but not all, some representatives of organized labor, but not all, opposed the legislation, urging us not to move forward until Congress considered the broader issue of how States would fit into the overall national health care reform package.

So today we will be examining that broader issue and looking at several of the States which have undertaken reform. Some are farther along than others. But each of their experiences will provide important lessons for us as we begin to shape our national program.

After Congress recesses this year, this subcommittee will be traveling to other States whose reforms combine some of the key elements of the President's proposal. That is, employer mandates, managed competition, insurance reform, global budgeting.

The President's plan, as you know, establishes a new national framework for a health care marketplace. States are responsible for implementing health care reform within this Federal framework.

A number of questions have been raised about this general approach. What are the basic Federal standards? How much flexibility should the States have to carry out these minimum standards? Should States be able to regulate and tax employers who provide coverage through their own health alliance? Should States be able to establish single-payer systems? What happens to employers running their own corporate alliances with employees within the State? Are the States willing and able to cope with establishing health alliances in dealing with global budgets? What if a State won't or can't do the task? Finally, how quickly can States be ready to implement health care reform?

Perhaps the most important questions are: What do the States expect from the Federal Government? What do we expect from the States, and are either expectations reasonable?

This morning's hearing will begin to explore some of these issues. I welcome our witnesses and I appreciate each of your willingness to be with us today and share your thoughts and counsel.

Mrs. Roukema?

Mrs. ROUKEMA. Thank you, Mr. Chairman.

I do appreciate the fact that we have set up this hearing today on these particular issues. The role of the States has only recently come to the fore in terms of the attention of the Congress and certainly the attention of the public as an essential component of the proposed health reforms that the Clinton administration has advanced.

The outline of that State role is still uncertain. As evidenced by recent newspaper reports, it is still under review and evolution, if not revolution.

But I would say, repeat to this group, as I have at each hearing that we have had, until we know with more specificity about the relative costs of the program and how those costs will be allocated, and a more realistic assessment as to what savings can be affected and where those savings will be affected, I think the other questions come down as subsections under the overarching question of realistic costs and organization.

I would also say that particularly with this issue on the role of the States and their relationship both to corporate plans as well as to the regional alliances, my favorite dictum probably holds true here as much, if not more so than any other area, which is over the years that I have studied health group care and health reform, the more you know, the more you realize you don't know, and I think this is going to be one of those areas. But I am very eager and interested in beginning that discussion today, and hopefully the panel here can give us some information based on their real life experiences.

Thank you very much, Mr. Chairman.

Chairman WILLIAMS. Ms. Woolsey?

Ms. WOOLSEY. Thank you for calling this hearing, Mr. Chairman, because it is so important that we talk about the role of States in health care reform. It is going to be crucial for the success of the program.

As many of you know, I am an advocate of the single-payer health care system, and I truly believe that we must make it possible for the voters in any State to have the right to choose a sin-

gle-payer system within the State. I was very glad to see in the news reports this weekend that the administration has agreed that States will be able to implement single-payer systems on a level playing field with all other choices. This means no required favors, no financial penalties for choosing a single-payer system.

So I continue to believe that if we all work hard together, this country is going to have the best health care system in the world. And I look forward to discussing the role of the States in the system with all of you this morning.

Thank you.

Chairman WILLIAMS. Mr. Fawell?

Mr. FAWELL. I have no opening statement.

Chairman WILLIAMS. Mr. Martinez?

Mr. MARTINEZ. Thank you, Mr. Chairman.

I am an advocate for the national health care plan. Always have been, always will be. I have had personal experiences of being without insurance at a time of a crisis and realized how it affects your family budget, et cetera, and I have also been involved, through my vocation and everything else, in a lot of the ideas that are encompassed in this national health care plan that the President is putting forth, as far as alliances, forming alliances with businesses, small businesses in order to be able to cover our employees when individually we could not. I have also, as a city councilman, been involved in determining what the costs of insurance is and what it should actually be.

You know, for years the problem is that the insurance companies controlled those costs. One time the mayor of the City of Monterey Park asked a finance officer to do an in-depth study of what it would cost to cover for fire and theft all of the houses in Monterey Park and what they were paying presently. After he did a real in-depth study of determining how many claims had been filed in the past year over the number of households in the city, et cetera, it finally boiled down to one bottom line. And that was that we could provide insurance for every household at one-tenth the cost the insurance companies were charging—one-tenth the cost—and still provide all of the fire and police costs with that premium. And more than that, if we let every house burn down and if every burglar was successful in removing every item from a house he burglarized, we would be able to replace that and cover that cost and still with only that small premium.

So the idea that numbers hold the cost down is not a new one; it is an old one. But beyond that simplistic statement comes the complication of how do you cover the people that are not covered, which I am not too sure about.

I have not seen the legalese of this bill, and I am very concerned about what we do to small businesses. I was a small businessman. And we made an arrangement with our employees after we formed this alliance to get insurance that we would pay 50 percent and they would pay 50 percent, and now this plan calls for 80–20, and although it does grandfather for 10 years those plans that are in existence if they meet a certain criteria, I am not sure what the criteria is, I am not sure that an alliance formed with local insurance companies couldn't do any better than the Federal Government could.

The Federal Government, however, does have a tool by which to negotiate prices and they do that already with the Federal insurance plans. We have over 127 I believe insurance companies that cover the Federal employees, but those prices or those contracts are negotiated by the Office of Personnel Management, with a very small staff, incidentally, and in a very cost-effective way.

And when you talk about single plan—single-payer plan, I have to agree with Ms. Woolsey that I am an advocate of the single-payer plan. I am also an advocate, which I don't think will ever happen, of a nationalized insurance plan to cover all of these people. I think it would be a lot simpler, because I have noticed in the past that every time we pass very complicated laws here in Congress, when they get to the agencies for promulgation of regulations, that law somehow gets convoluted and it gets convoluted even farther as the maze of the agencies tries to deal with the problems that arise and that they are told that they must control through that legislation.

I am looking forward to the testimony, especially from the States, and regarding how those States, Oregon, Florida, I think it is, several States, Hawaii, have already passed plans that evidently would cover every person in their State, and evidently have dealt with the problem of small businesses already and how we get around incurring too great a cost on those small businesses so that we force more out of business.

We are at a time in our history when we can't afford to lose any more business, small or large. We have another proposition going on here that would move jobs abroad, and we are going—pondering with that. So I am one that looks forward to the testimony.

I do have the leave early, Mr. Chairman, for a short while to receive a call from the Secretary of Labor, but I will return.

Thank you, Mr. Chairman.

Chairman WILLIAMS. Thank you.

Mr. Ballenger?

Mr. BALLENGER. No opening statement.

Chairman WILLIAMS. Mr. Boehner?

Mr. BOEHNER. No.

Chairman WILLIAMS. Mr. Hoekstra?

Mr. HOEKSTRA. No.

Chairman WILLIAMS. Well, we will turn now to our panel. Our first witness is Delaware Senator John Still. Senator Still is also Chairman of the National Conference of State Legislatures' Health Committee.

Senator, it is nice for you to be with us. Please proceed.

STATEMENT OF HON. JOHN STILL, DELAWARE STATE SENATOR, CHAIR, HEALTH COMMITTEE, NATIONAL CONFERENCE OF STATE LEGISLATURES

Mr. STILL. Thank you, Mr. Chairman, distinguished members of the subcommittee.

As you said, my name is John Still. I am a member of the Delaware State Senate, and today I am speaking on behalf of the National Conference of State Legislatures where I serve as the Health Committee Chair. NCSL's health care committee guides our policy

on health matters and has primary jurisdiction over issues regarding health care reform.

I am pleased to be here today to discuss the State role in President Clinton's health care reform proposal. NCSL has endorsed no specific plan or approach. Our goal is to help craft a plan that provides for health care coverage for all residents of the United States, Federal guidance with a strong, meaningful role for States in program design and implementation, and lastly, equity for and between States as well as maintaining a strong fiscal base. What I will try to do is just touch these in bullet form for you, if I may.

First, we believe State flexibility is essential. While we agree that some national uniformity is desirable, NCSL rejects the notion of one size fits all, and we will actively oppose Federal preemption unless it is necessary to achieve a compelling national objective and the preemption is the only reasonable means of correcting the problem.

The appropriate role of the Federal Government is to set national standards where needed and to establish goals. States should determine the best way to meet the goals and implement the national standards. Efforts must be made to assure equitable treatment for States and between States.

It is important to pay special attention to the State-by-State and regional impacts of health care reform proposals. We believe that every effort must be made to avoid adverse State and regional effects. A firm fiscal base is necessary.

What do we mean by that? A firm fiscal, financial foundation is critical to the establishment and the full implementation of a comprehensive health care reform proposal. This may mean that eligibility and/or coverages will need to be phased in over time.

We support the goals and the basic principles of President Clinton's proposal. NCSL applauds the leadership that President Clinton has provided in calling for health care reform and his efforts to guarantee cradle-to-grave coverage should not go unnoticed.

I would like to spend the remainder of my brief time with you to discuss President Clinton's proposal in some of our areas of concern. First, the National Health Board, NHB. NCSL opposes and disagrees with the proposed roles and responsibilities of the National Health Board. While we are extremely pleased that the States would be officially represented on the NHB, we believe that far too much power is vested in the seven-member board.

Number two, there are certainly areas where the national uniformity is both necessary and desirable, but we believe more efforts should be invested in ferreting out just what those areas are. NCSL is not willing to cede State authority in areas where there is no clear need to do so.

Number three, NCSL supports the establishment of several federally established standard benefit packages. We also believe that States should continue to regulate and to ensure that a range of plans that provide the standard coverages is available to all covered individuals.

The President's proposal would establish a Federal consumer protection framework by mandating the establishment of a State health alliance agreements procedure. This is a function currently carried out by State insurance commissioners. We prefer to con-

tinue the oversight responsibilities of our insurance commissioners to the establishment of a Federal grievance framework program.

Next, the National Health Board would establish and enforce budget targets. If targets are established, States should have a role in developing them, should enforce them and should be permitted to utilize that full range of strategies available to control costs, while maintaining quality and improving access.

Next, the National Health Board has been given broad authority to regulate the regional health alliances. Again, we believe that the Federal Government should develop some broad guidelines and let States determine the structure, function and governance of the health alliances. We would also urge more flexibility regarding the designation of alliance boundary lines.

Next, the National Health Board would also be given the authority "to designate certain providers as essential community providers," unquote. This requirement is designed to ensure that providers that have traditionally provided care to the poor and the underserved will be afforded an opportunity to participate in the new system. NCSL supports this concept, but believes the designates of these providers should be a State function at the local level done in collaboration with local governments and local providers.

Next, the Clinton proposal would preempt a broad range of State laws. We believe that all Federal preemption should be carefully scrutinized. Examples include the preemption of State anti-managed care laws, laws that regulate utilization review companies and State scope-of-practice laws are other examples which would be preempted.

Next, the President wants to fully integrate the health component of worker's compensation and automobile insurance into the comprehensive reform package. NCSL believes the States must be assured that the core values, such as broad coverage, safe and healthful workplaces, prompt and high-quality care are preserved and that neither the liability nor the exclusive remedy doctrine be altered. This area of change needs careful consideration and input from State governments and the National Association of Insurance Commissioners.

Let me turn our attention to the participation portions of the President's proposal. First, we support full integration of the individuals receiving acute care through the Medicaid program. We support the provision in the Clinton proposal that would permit States to include Medicare eligible individuals into the regional health alliances.

We also see strong public policy basis for the broad establishment of corporate alliances. While we agree that some employers may in fact require special consideration, we believe the vast majority of employers, regardless of size, could participate in the regional health alliances.

Thus, we are particularly concerned about firms initially establishing corporate alliances and then, for whatever reasons, deciding to put their employees into the regional alliances. The local impact of such changes have both budget and service delivery implications.

Next, the Federal Government should address the problem of providing health care coverage for undocumented individuals squarely. It has been suggested that some funding will be set aside

to reimburse hospitals for care they provide to the undocumented individuals, and that the administration would continue emergency coverage for these individuals under Medicaid. A more detailed and adequate response to this problem is essential.

Next, NCSL supports the President's proposal to provide health care coverage through the alliances to certain early retirees. This initiative will provide substantial fiscal relief to State governments, as it will to many of the major corporations that provide retiree coverage.

Next I would like to briefly talk about the financing. NCSL believes that the new system must be adequately financed. We should make every effort to avoid promising more than we can deliver with the resources that are available. If the plan includes an employer mandate, subsidies for small at-risk businesses should be provided.

NCSL supports mandatory participation by individuals and believes that subsidies should also be available for low-income individuals and their families. We oppose the establishment of subsidies as a capped entitlement subject to the appropriations process.

We support the proposal to permit self-employed individuals to enjoy the same tax deductibility status and benefits afforded to other businesses.

The 7.9 percent cap on premiums does not apply to States and local governments. We oppose this provision. While we have not done a complete analysis of the impact of this proposal on State governments on a State-by-State basis, we already know that low-wage States are adversely affected. We will work with the administration on this issue to develop a reasonable compromise.

We are concerned about what we believe are unrealistic savings the administration hopes to squeeze from the Medicaid and Medicare programs. We are equally, if not more concerned about the proposal's State maintenance effort requirements that will lock States in where they are today, freezing existing inequities in the current Medicaid program in place. This proposal could adversely affect those States with more generous Medicaid programs.

We urge the administration to repeal the Boren amendment. Repealing this provision would provide substantial fiscal relief to States. The plan would continue the restrictions placed on States regarding provider-related taxes. It prohibits States from imposing a payroll tax to fund health care reform activities and may include some sort of insurance premium cap. We oppose these provisions.

Next, the premium tax is a traditional State revenue source.

Chairman WILLIAMS. Let me interrupt to ask you to summarize. You are well over your time limit, and while we do want to hear your statement in its entirety, you know whether or not you have a considerable amount left, and if so, I would ask you to summarize it.

Mr. STILL. Okay. We are just about finished here. Let me jump to the conclusion, if I may, then.

In summary, our goals to be active participants in developing a comprehensive reform strategy that provides for universal coverage; number two, a strong role for States in program design and implementation; number three, equity for and between States; and

number four, a firm fiscal foundation. We will apply these principles to each health care reform proposal that we observe and have the opportunity to look at.

I appreciate this opportunity to share our initial views regarding President Clinton's health care proposal, and we look forward to working with all of you over the coming months. Thank you.

[The prepared statement of Mr. Still follows:]

SENATOR JOHN STILL, DELAWARE

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE:

MY NAME IS JOHN STILL. I AM A MEMBER OF THE DELAWARE STATE SENATE AND TODAY I AM SPEAKING ON BEHALF OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES (NCSL) WHERE I SERVE AS CHAIR OF THE HEALTH COMMITTEE. NCSL REPRESENTS THE LEGISLATURES OF THE FIFTY STATES, ITS COMMONWEALTHS, TERRITORIES AND THE DISTRICT OF COLUMBIA. NCSL'S HEALTH COMMITTEE GUIDES OUR POLICY ON HEALTH MATTERS AND HAS PRIMARY JURISDICTION OVER ISSUES REGARDING HEALTH CARE REFORM. I UNDERSTAND THAT THE JURISDICTIONAL ISSUE IS ONE YOU ARE STRUGGLING WITH HERE IN WASHINGTON, D.C. I SYMPATHIZE AND CAN SAY THAT ALTHOUGH MY COMMITTEE HAS PRIMARY JURISDICTION, WE TOO ARE WORKING CLOSELY WITH A NUMBER OF OTHER COMMITTEES AND THE NCSL EXECUTIVE COMMITTEE ON THIS ISSUE.

MY TESTIMONY TODAY IS BASED ON POLICIES ADOPTED BY NCSL'S STATE-FEDERAL ASSEMBLY (SFA), THE POLICYMAKING BODY THAT GUIDES OUR ADVOCACY ACTIVITIES WITH CONGRESS, THE COURTS AND THE FEDERAL ADMINISTRATION. NCSL POLICIES REFLECT OUR DEDICATION TO PRESERVING A STRONG FEDERAL SYSTEM OF GOVERNMENT, MAINTAINING EFFECTIVE INTERGOVERNMENTAL PROGRAMS, PROTECTING OUR NATION'S VULNERABLE POPULATIONS, AND DEVELOPING CREATIVE, CONSTRUCTIVE DOMESTIC INITIATIVES, AND FORGING AN EFFECTIVE STATE-FEDERAL HEALTHCARE REFORM PARTNERSHIP.

I AM PLEASED TO BE HERE TODAY TO DISCUSS THE STATE ROLE IN PRESIDENT CLINTON'S HEALTH CARE REFORM PROPOSAL. AS YOU KNOW, THE PRESIDENT IS TENTATIVELY SCHEDULED TO PRESENT HIS LEGISLATIVE PACKAGE TO YOU SHORTLY. OVER THE WEEKEND, THE ADMINISTRATION WAS CONTINUING TO FINE TUNE THE PROPOSAL. I AM COMMENTING TODAY USING MY BEST KNOWLEDGE OF THE 240 PAGE VERSION OF THE PLAN.

THE DEBATE ON NEEDED HEALTH CARE REFORM IS JUST BEGINNING. NCSL HAS ENDORSED NO SPECIFIC PLAN OR APPROACH. OUR GOAL IS TO HELP CRAFT A PLAN THAT PROVIDES FOR: (1) HEALTH CARE COVERAGE FOR ALL RESIDENTS OF THE UNITED STATES; (2) FEDERAL GUIDANCE WITH A STRONG, MEANINGFUL ROLE FOR STATES IN PROGRAM DESIGN AND IMPLEMENTATION; (3) EQUITY FOR AND BETWEEN STATES; AND (4) A STRONG FISCAL BASE.

The only way to provide full access and to control health care costs is to establish a program where everyone is covered. While we agree that some national uniformity is desirable, NCSL rejects the notion of "one size fits all" and will actively oppose federal preemption unless it is necessary to achieve a compelling national objective and the preemption is the only reasonable means of correcting the problem. The appropriate role of the federal government is to set national standards, where needed, and to establish goals. States should determine the best way to meet the goals and to implement the national standards. It is important to pay special attention to the state-by-state and regional impact of health care reform proposals. We believe that every effort must be made to avoid adverse state and regional effects. Finally, a firm financial foundation is critical to the establishment and the full implementation of comprehensive health care reform. This may mean that eligibility and/or coverage will need to be phased-in over time.

We support the goals and basic principles of President Clinton's proposal. NCSL applauds the leadership that President Clinton has provided in calling for health care reform and his efforts to guarantee cradle to grave health care coverage. I would like to spend the remainder of my brief time with you to discuss President Clinton's proposal and some of our areas of concern.

National Health Board

NCSL opposes and disagrees with the proposed roles and responsibilities of the National Health Board (NHB). While we are extremely pleased that states would be officially represented on the NHB, we believe that far too much power is vested in the seven member board. This is an area where we feel the administration should concentrate more on the big picture and leave the detail work to us. There are certainly areas where national uniformity is both necessary and desirable, but we believe more effort should be invested in ferreting out just what those areas are. NCSL is not willing to cede state authority in areas where there is no clear need to do so.

NCSL supports the establishment of several a federally established standard benefit packages that would include insurance guidelines and operating

standards. We also believe that states should continue to regulate insurance including supplemental coverage and that states should ensure that a range of plans that provide the standard coverages is available to all covered individuals. In addition, the President's proposal would establish a federal consumer protection framework by mandating the establishment of a state health alliance grievance procedure. This is a function currently carried out by state insurance commissioners. We prefer to continue the oversight responsibilities of our insurance commissioners to the establishment of a federal grievance framework or program.

Under the Clinton proposal, the NHB would establish and enforce budget targets. NCSL has taken no position on whether budget targets should be established, but has taken the position that, if targets are established, states have a role in developing them. We further believe that if targets are established, and it seems that they will be, that states, not the NHB, should enforce them and should be permitted to utilize the full range of strategies available to control cost while maintaining quality.

The NHB has been given broad authority to regulate the regional health alliances. States should have the primary regulatory authority over the regional health alliances and should not serve merely as the administrative arm of the NHB. Again we believe that the federal government should develop some broad guidelines and let states determine the structure, function and governance of the health alliances. We would also urge more flexibility regarding the designation of alliance boundary lines. For instance, we are not at all certain that the requirement that alliances be established by SMSA is desirable or workable.

The NHB would also be given the authority to designate certain providers as "essential community providers". Certified health plans would be required to include these providers in their networks for a specified period of time. This requirement is designed to ensure that providers that have traditionally provided care to the poor and the underserved will be afforded an opportunity to participate in the new system. NCSL supports this concept. NCSL policy calls for the inclusion of community health centers, school clinics, public health

clinics and other community providers in the network of providers eligible to provide services as long as they meet the established standards and are certified to operate. How can the federal government know who is an essential community provider in my community or in my state? The designation of these providers should be a state and local government function.

The Clinton proposal would preempt a broad range of state laws. We believe that all federal preemption should be carefully scrutinized. States, over the past several years have enacted a body of law that has in some quarters been characterized as "anti- managed care". These laws set limits on how managed care providers can operate within the state and regulate utilization review companies. The Clinton plan suggests that these state laws be preempted, but says little about what the federal government will do to protect consumers and ensure quality. The proposal would also preempt state "scope of practice" laws. These laws establish the scope of practice of health professionals licensed or certified to practice in the state. While the federal goal of expanding access through the use of physician assistants, nurses, and allied health professionals, we believe this is an area better left to the level of government that licenses and certifies the providers.

Finally, we know that the President wants to fully integrate the health component of workers compensation and automobile insurance into the comprehensive reform package. While NCSL has no formal position on whether or not they should be included, we believe that states must be assured that the core values, such as broad coverage, safe and healthful workplaces, prompt and high quality health care, are preserved and that neither the liability nor the exclusive remedy doctrine be altered.

Participation

NCSL believes that participation in the regional health alliances should be as inclusive as possible. We support full integration of the individuals receiving acute care Medicaid population, but have reservations regarding the establishment of corporate alliances. We support the provision in the Clinton proposal that would permit states to include medicare-eligible individuals into the regional health alliances. With respect to long term care, we support

efforts to expand home and community-based care services to the severely disabled, and would like to discuss options for improving the Medicaid institutional long term care program.

As state legislators, we have extensive experience with the Medicaid program. The program has propped up our weak health care system for a number of years now, but does not provide a firm foundation for a new system. We believe if there is ever to be equity in our health care system, we must decouple health care services from eligibility for cash assistance programs. There are complications. Some people will no longer be eligible for benefits, that are provided under Medicaid, but fail to make the cut in the national standard benefit. This is an important issue that must be addressed. We are not convinced that the only way to address this issue is to continue the Medicaid program.

We also see no strong public policy basis for the broad establishment of corporate alliances. While we agree that some employers would experience some difficulty, and may in fact require special consideration, we believe the vast majority of employers, regardless of size, could participate in the regional health alliances. We are particularly concerned about firms initially establishing corporate alliances and then for whatever reasons, deciding to put their employees in regional alliances. The local impact of such changes have both budget and service delivery implications.

We understand the public policy concerns regarding coverage of undocumented individuals; however, we feel strongly that the federal government should address this problem squarely. As states, we have no ability or authority to control the flow of undocumented individuals. We should not therefore be left, unassisted or inadequately assisted, to provide health care to them. It has been suggested that some funding will be set aside to reimburse hospitals for care they provide to undocumented individuals and that the Administration would continue emergency coverage for these individuals under Medicaid. A more detailed and adequate response to this problem is essential.

NCSL supports the President's proposal to provide health coverage through the alliances to certain early retirees. This initiative will provide substantial fiscal relief to state governments.

Financing

NCSL believes that the new system must be adequately financed. We should make every effort to avoid promising more than we can deliver with the resources that are available.

While NCSL has taken no position on whether or not employers should be required to contribute towards the health care coverage of their employees, we believe that, if such a requirement is included in the plan, subsidies for small, at-risk businesses should be provided. NCSL supports mandatory participation by individuals and believes that subsidies should also be available for low income individuals and their families. The Clinton proposal provides for subsidies, but it has been suggested that these subsidies would be established as a "capped entitlement", subject to the appropriations process. We oppose this proposal. If the mandate for businesses and individuals will be in effect, the subsidies should be guaranteed. We support the proposal to permit self-employed individuals to enjoy the same tax deductibility benefits afforded to other businesses.

The Clinton proposal provides that most employers would pay no more than 7.9 percent of payroll as a contribution to their employee's health care coverage. Exempted from this "cap on premiums", are companies that opt to establish corporate alliances, and state and local governments. We oppose this "special exception". While we have not done a complete analysis of the impact of this proposal on state governments, we do know that low-wage states are adversely affected. We will work with the Administration on this issue.

We are concerned about what we believe are unrealistic savings the Administration hopes to squeeze from the Medicaid and Medicare programs. We are equally, if not more concerned about the proposal's state maintenance of effort requirements that will lock states in where they are today, freezing existing inequities in the current Medicaid program in place. This proposal could adversely affect those states with more generous Medicaid programs. Finally, if we are to continue operating a Medicaid program, we urge the Administration to repeal the Boren amendment. The repeal of this provision would provide substantial fiscal relief to states.

Finally, the President's plan affects state taxes in a number of ways. The plan would continue the restrictions placed on states regarding provider-related taxes; prohibits states from imposing a payroll tax to fund health care reform activities; and may include some sort of insurance premium cap. We oppose these provisions. NCSL firmly believes that who states tax and how they tax them is purely a state matter. The premium tax is a traditional state revenue source that we believe should not be compromised.

As another example, the President has proposed to increase the federal sales tax on cigarettes to 75 cents. Sin taxes are another traditional state revenue source. Currently many states fund health programs with a portion of their sales tax on cigarettes. We hope that the federal government will include the cigarette tax revenue we as states will lose, as part of our financial contribution to the health plan.

Transition

Vice President Gore, in his recently released National Performance Review, strongly urges the development of an expedited and expanded waiver process. NCSL strongly supports this proposal. We further believe that, while the federal government debates the details of health care reform, states should be afforded maximum flexibility to begin innovative reform of their health care delivery systems. NCSL supports the establishment and implementation of an expedited waiver process by which states can receive multi-year waivers of requirements under Medicaid, Medicare, ERISA and other federal laws to implement state reforms.

Conclusion

In summary, our goal is to be active participants in developing a comprehensive reform strategy to provides for: (1) universal coverage; (2) a strong role for states in program design and implementation under general federal guidance; (3) equity for and between states; and (4) a firm fiscal foundation. We will apply these principles to each health care reform proposal.

I appreciate this opportunity to share our initial views regarding President Clinton's health care reform proposal with you and I look forward to working with all of you over the coming months.

Thank you and I would be happy to answer any questions you may have.

Chairman WILLIAMS. Thank you.

Alan Weil is the Health Policy Advisor to Governor Roy Romer of Colorado.

Thank you for coming out to be with us.

STATEMENT OF ALAN WEIL, HEALTH POLICY ADVISOR TO GOVERNOR ROY ROMER

Mr. WEIL. Good morning, Mr. Chairman, members of the subcommittee.

As you stated, my name is Alan Weil. I am the health policy advisor to Colorado Governor Roy Romer. I thank you for the opportunity to present my testimony to you this morning.

I will cover four topics in my remarks. First, although I am not here representing the National Governors' Association, I would like to share with you the policy of the NGA on State-Federal issues with respect to health care reform.

On February 1, 1993, when Governor Romer was Chair of the NGA, the association unanimously adopted a policy in support of comprehensive health care reform for this country. That policy called for a national framework of managed competition with State and local management of the system. You will find a copy of that policy attached to my written testimony.

Governors understand the need for national action on health care reform. There are certain issues that can only be addressed at the national level, there are some barriers that the Federal Government currently imposes on States that need to be removed, and there are some issues where national uniformity makes for the best health care policy. All of these issues create a need for Federal action to guarantee universal access, design a basic benefit package, establish data collection standards, undertake outcomes research, standardize insurance regulation and make decisions about the tax deductibility for health insurance.

Within this framework, States are prepared to take responsibility for managing the system. States can establish and monitor health alliances, ensure access throughout each State, and work with and regulate health plans to make the system work. Governors do not want a federally-administered health care system. Governors are prepared to operate systems within a national framework.

Second, governors have worked closely with this administration on issues related to State flexibility in program design. At the winter meeting of the NGA, President Clinton asked governors to work with his administration in designing his health care proposal. Seven governors' staff members, four Democrats and three Republicans, participated in the design of the Federal program. I was one of those seven staff members.

Governors worked in a bipartisan manner with the administration to make sure that State-Federal issues were addressed appropriately in the President's plan. While we all await the final legislative language, based upon the September 7 draft proposed by the President, governors made comments on the State-Federal structure of the plan.

Governors said: The NGA supports the strong State-Federal partnership that is the framework of President Clinton's health care plan. Specifically, governors support State administration of

the program, and governors are comfortable with the timelines established for States putting their plans into place. You will find the full text of the governors' comments attached to the written testimony.

Third, I would like to give a sense of how Colorado is preparing to respond to the President's proposal. Earlier this year, Colorado enacted legislation restructuring its State government. On July 1, 1994, we will create a new Department of Health care policy and finance that will house the State's Medicare program as well as any new universal access program we might put into place. Thus, we are already taking steps to prepare for whatever work we might have to do as our part of a national health care plan.

In addition, we have been working on our own health care reform proposal. Our plan, known as ColoradoCare, is a comprehensive health reform plan that would provide all Coloradans with a choice of privately administered health plans. We released a preliminary feasibility report on ColoradoCare this summer, and you will find the executive summary of that report in your written testimony.

While ColoradoCare and the President's plans have some important differences, they are in many ways similar. We found, as did the administration, that a well-designed health care reform proposal could lead to significant long-term cost savings, while ensuring uninterrupted coverage for all people. We have held 20 public hearings in Colorado. We have found the public is very interested in health care reform.

My point is that Colorado, just as one State, has done the homework necessary to prepare for implementation of a reformed health care system. We look forward to taking the steps necessary to do our part within the national framework of health care reform.

Finally, let me make a few comments about the ERISA law and its effect on State health care reform. ERISA is one of the most misunderstood laws in the minds of the public. While we have already seen the preemptive effects on States of some health-care-related efforts, we do not yet know the full extent of the barrier that ERISA presents to comprehensive reform efforts.

The cloud of a possible ERISA lawsuit adds yet one more barrier to States acting in the area of health care reform. Why would we expend the tremendous amounts of political and administrative energy in designing a health care reform proposal only to have it thrown out or put on hold due to a legal challenge?

Certainly, comprehensive national health care reform would eliminate many of the concerns that currently relate to ERISA preemption. I hope that complex issue is resolved in the context of comprehensive reform. However, if for some reason you are unable to put into place a national framework for health care reform, I hope that you will be able to remove at least one barrier States face right now, and that is the effect of ERISA preemption.

Let me close by saying that governors have a keen interest in national health care reform. There are many issues that I didn't discuss here on which governors have opinions. On some of those, governors have reached consensus; on others, they have agreed to disagree. However, in the area of State-Federal relations, I believe there is significant agreement among governors about the correct

structure. They have endorsed a Federal framework with State and local management.

Thank you for the opportunity to present this testimony to you this morning.

[The prepared statement of Mr. Weil follows:]

Testimony Before the Subcommittee on Labor-Management Relations, Committee on Education and Labor, U.S. House of Representatives

Submitted by Alan Weil

October 26, 1993

Good morning, Mr. Chairman and members of the subcommittee. My name is Alan Weil, and I am the Health Policy Advisor to Colorado Governor Roy Romer. Thank you for the opportunity to present this testimony to you. I will address four topics in my remarks.

First, I would like to share with you the policy of the National Governors' Association on state-federal issues with respect to health care reform. On February 1, 1993, when Governor Romer was chair of the NGA, the association unanimously adopted a policy in support of comprehensive health care reform for this country. That policy called for a national framework of managed competition, with state and local management of the system. I have attached a copy of that policy to this testimony.

Governors understand the need for national action on health care reform. There are certain issues that can only be addressed at the national level, there are some barriers that the federal government currently imposes on states that need to be removed, and there are some issues where national uniformity makes for the best health care policy. All of these issues create a need for federal action to guarantee universal access, design a basic benefit package, establish data collection standards, undertake outcomes research, standardize insurance regulation, and make decisions about the tax deductibility for health insurance.

Within this framework, states are prepared to take responsibility for managing the system. States can establish and monitor health alliances, ensure access throughout the state, and work with and regulate health plans to make the system work. Governors do not want a

federally administered health care system. Governors are prepared to operate systems within a national framework.

Second, governors have worked closely with the administration on issues related to state flexibility in program design. At the winter meeting of the NGA, President Clinton asked governors to work with his administration in designing his health care proposal. Seven governor's staff members, four Democrats and three Republicans, participated in the design of the federal program. I was one of those seven staff members.

Governors worked in a bipartisan manner with the administration to make sure that state-federal issues were addressed appropriately in the President's plan. While we all await the final legislative language, based upon the September 7 draft proposal by the President, governors made comments on the state-federal structure of the plan. Governors said: "The [NGA] supports the strong state/federal partnership that is the framework of President Clinton' health care plan." Specifically, governors support state administration of the program, and governors are comfortable with the time lines established for states putting their plans into place. The full text of the governors' comments are attached to this testimony.

Third, I would like to give you a sense of how Colorado is preparing to respond to the President's proposal. Earlier this year, Colorado enacted legislation restructuring its state government. On July 1, 1994, we will create a new Department of Health Care Policy and Financing that will house the state's Medicaid program, as well as any new universal access program we might put into place. Thus, we are already taking steps to prepare for whatever work we might have to do as our part of a national health care plan.

In addition, we have been working on our own health care reform proposal. Our plan, known as ColoradoCare, is a comprehensive health reform plan that would provide all

Coloradans with a choice of privately administered health plans. We released a preliminary feasibility report on ColoradoCare this September. The executive summary of that report is attached to this testimony. While ColoradoCare and the President's plans have some important differences, they are in many ways similar. We found, as did the administration, that a well-designed health care reform proposal could lead to significant long-term cost savings while ensuring uninterrupted coverage for all people. We have held twenty public hearings in Colorado, and we have found that the public is very interested in health care reform.

My point is that Colorado, as just one state, has done the homework necessary to prepare for implementation of a reformed health care system. We look forward to taking the steps necessary to do our part within a national framework of health care reform.

Finally, let me make a few comments about the ERISA law and its effect on state health care reform. ERISA is one of the most misunderstood laws in the minds of the public. While we have already seen the preemptive effects on states of some health-care related efforts, we do not yet know the full extent of the barrier that ERISA presents to comprehensive reform efforts.

The cloud of a possible ERISA lawsuit adds yet one more barrier to states acting in the area of health care reform. Why expend the tremendous amounts of political and administrative energy in designing a health care reform proposal only to have it thrown out or put on hold due to a legal challenge?

Certainly, comprehensive, national health care reform would eliminate many of the concerns that currently relate to ERISA preemption. I hope that this complex issue is resolved in the context of comprehensive reform. However, if for some reason you are unable to put into place a national framework for health care reform, I hope that you will

be able to remove at least one barrier that states face right now, and that is the effect of ERISA preemption on the design and implementation of comprehensive health care reform proposals.

Governors have a keen interest in national health care reform. There are many issues related to health care reform that I did not discuss here on which governors have opinions. On some of those issues governors have reached consensus--on others they have agreed to disagree. However, in the area of state-federal relations, I believe that there is significant agreement among governors about the correct structure. Governors have endorsed a federal framework with state and local management.

Again, I thank you for the opportunity to present these ideas to you this morning.

NATIONAL GOVERNORS' ASSOCIATION

Governor of Colorado
Chairman

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NATIONAL HEALTH REFORM AND COST CONTAINMENT

1. Introduction

The United States spends more on health care than any other industrialized nation even though fewer of our citizens have insured access to the health care system. Moreover, growth in the American health care industry has exceeded growth in the overall U.S. economy for almost every one of the last thirty years. As a result, health care expenditures represent an increasing share of the economy as measured by the gross domestic product (GDP). In 1980 health care was approximately 9.1 percent of GDP; in 1992 it represented 13.4 percent; and it is projected to represent about 17 percent of GDP by the turn of the century if current trends continue.

This phenomenal growth in costs has negatively affected government at every level and has seriously eroded the competitive edge of our businesses attempting to compete in a global marketplace.

Clearly the nation cannot sustain the current rate of growth in health care costs. If the system is expanded to include universal coverage without reform, the cost problems will be greatly exacerbated. While people may argue about the final target for an acceptable rate of growth in costs, the nation must develop a health care system that over the next several years will move growth in costs toward a long-term sustainable level.

The kinds of structural changes that must occur in the health care system to control costs cannot be effective unless and until every legal resident has health insurance. Universal access to health care is both a moral imperative and an invaluable cost containment tool.

2. Basic Federal Framework

The Governors support a managed competitive approach to health care reform that is organized by the federal government. However, attention must be paid to ensuring that the approach will work in both rural and inner-city areas. Toward that end, the federal government should establish a national health care board that includes state and local representation. Much of the framework for implementing managed competition could be accomplished by the national board.

The basic and fundamental federal framework for a restructured health care system that both controls costs and provides access and coverage must, at a minimum, include the following.

- **Universal access.** Universal access to health care coverage should be guaranteed to every American. States should have the option of providing access to health care either through public or private programs or through an employer mandated system similar to those pursued in Kentucky, Oregon, and Hawaii.
- **A standardized and federally organized information base for consumers.** The database must include price and quality information for all providers of health care services in a given geographic area.
- **Federally organized national outcomes research.** One component of such research should focus on primary and preventive care. Among other uses, this research could be used as a basis for clinical practice models.
- **Federal minimum standards for the regulation of health insurance.** These minimum standards must be developed in consultation with states and include limitations on the variation in rates that different individuals and groups charge; limitations on medical underwriting; and guaranteed renewability, portability, and availability of insurance products. States can exceed these minimum standards. These standards should apply to nontraditional insurance mechanisms, such as Multiple Employee Welfare Arrangements (MEWAs) and other ERISA plans,

and to newly formed Health Insurance Purchasing Cooperatives. Once reforms are implemented, individuals bear a personal responsibility to obtain coverage either through public or private programs. The cost of coverage would be supplemented for low-income individuals.

- **State-organized purchasing cooperatives.** Through purchasing cooperatives, affordable insurance products will be made available. States and the federal government must work together to ensure that states have flexibility in establishing and operating purchasing cooperatives within a national framework. Purchasing cooperatives should allow for public or private operation under state regulation.
- **Tort and liability reform standards.** Tort and liability standards for health care should be developed by the federal government. However, states must have the flexibility to design and regulate their own programs that meet the federal standards or further limit liability.
- **A single national claims form.** The federal government, in consultation with states, must develop a single claims form and support the development of electronic billing as a means to reduce administrative costs. A single electronic claims form system will simplify the administrative procedures for all health care participants, including hospitals, physicians, insurers, employers, government, and consumers.
- **Core benefits package.** The federal government, in consultation with states, localities, businesses, and labor organizations, must develop a core benefits package comparable to those now provided by the most efficient and cost-effective health maintenance organizations. There may be some state or regional variations in the basic benefit package, but such variations must be certified by a national health care board. Individuals would be free to purchase additional insurance with after-tax dollars. This package could be adjusted as additional information from outcomes research becomes available.
- **Limitations on tax deductibility of health insurance.** The federal tax code must be amended to limit the tax deduction/exemption of health insurance for both employers and employees. Employer-paid insurance above the limit would be taxable to either the employer or employee. The self-employed would be eligible to purchase fully deductible health insurance -- exempt from taxation as personal income -- within the federal limit and/or tied to a percentage of an income level. This limit may be tied to the local cost of a basic benefit package and set at a specific dollar amount. Additional coverage or care can be purchased with after-tax dollars.
- **Primary and preventive care.** The federal government must greatly expand its support for primary and preventive care including, but not limited to, periodic health screenings, prenatal care, well-baby care, and childhood immunizations.

3. **Specific Cost Containment Strategies**

Even if a federal framework is established that adheres to the principles just described, a real possibility exists that the federal government will attempt cost control by capping the federal medical entitlement programs. A cap only on federal health care entitlement programs will most certainly continue to shift costs to the private sector and local governments and reduce real benefits. A more effective strategy is to control costs throughout the health care system by developing health care expenditure targets.

It is unrealistic to immediately enforce strict budget limits on health care spending, since available data are not sufficient to set accurate spending ceilings. However, the national framework, developed in consultation with the states, should include cost control mechanisms which should be implemented by the states as quickly as possible. Cost containment strategies must consider all the major cost-drivers in the health care and health insurance systems. Incentives such as expedited waivers and Medicaid demonstrations must also be available to contain costs.

- Goals for the growth of national health care expenditures should be established for expenditures that are publicly supported either directly or through the tax code. Health care expenditures made by individuals with after-tax dollars would not be included in the targets. The national goals should be used to estimate expenditure targets for each state.
- Data systems necessary to objectively measure national and state health care expenditures must be established.
- As data become available, there should be a review of the progress the federal and state governments have made toward achieving the national expenditure goals.

- The federal government should issue an annual report to the states that addresses the following.
  - The effectiveness of our health care expenditures toward producing and maintaining health for all of our citizens. The data should be presented in at least the following categories: populations, state-by-state, urban and rural, fee-for-service, various types of managed care, and comparative therapies.
  - The status of data system improvements, including the development of data categories, sample sizes, and timeliness.
  - The progress or failure of each state toward any state or per capita expenditure goals.

4. **State and Local Management**

Within the context of a managed competitive approach to health care reform that ensures universal access and controls costs, the Governors support the principle of state and local management. State and local governments will need a set of tools to manage a cost-effective health care system.

- States wishing to undertake reforms which complement the federal framework described above and which are aimed at significantly expanding access to health care and controlling health care costs should be encouraged to move ahead in advance of full implementation of national reforms and should be given the tools necessary to be successful. For example, Governors encourage prompt approval of the Oregon waiver request.
- Assuming that there still is a public program, even if that public program is modeled after Medicaid, state and local governments will need stable financing and a uniform definition of eligibility. Beyond that, however, state and local governments must be given the flexibility and authority to fully integrate the public program into a service delivery system that reflects the national movement toward managed care. The federal government must not impose mandates beyond the core benefits or service delivery restrictions on the public program. A streamlined and efficient public program will obviate the need for the complex and costly waiver process.
- If Medicare continues to exist as a separate program, state and local governments will need the flexibility to fully integrate Medicare into their health care systems.
- States must have the ability to include the current self-insured market (ERISA plans) in their state design.
- States must have additional authority now precluded by federal anti-trust statutes.

5. **Additional Federal/State Issues**

- The federal government must participate in a discussion about how to deal with the access issues of rural areas, inner cities, and populations currently financed by federal programs, including Native Americans, veterans, and dependents of military personnel. The federal government also must participate in discussions about the provision of care to undocumented aliens.
- The federal government must reaffirm the traditional role of public health programs including epidemiology, environmental health, and disease prevention while integrating primary and preventive care services into the core benefits package to the extent possible. Adequate federal resources and technical assistance must be provided to ensure that the public health needs of states and communities can be met.
- Federal, state, and local governments must work toward agreement on a long-term care program that recognizes the need for different levels of care and support either within or outside a health care institution.

The Governors are prepared to work with other interested organizations and with the President and Congress to flesh out the details of specific proposals and then to secure formal support and enactment.

Time limited (effective February 1993-February 1995).

Adopted February 1, 1993.

National Governors' Association

Comments on

President Clinton's Health Care Plan:
State/Federal Issues*

The National Governors' Association (NGA) supports the strong state/federal partnership that is the framework of President Clinton's health care plan. The Governors are committed to supporting the President's stated goals of reducing the rate of growth of health care spending and making coverage available for all Americans.

The Governors appreciate the meaningful consultation process between the President's Health Care Task Force and NGA on the design of a plan that is state based. Substantial state flexibility must be maintained in any plan. The President's plan would reflect state differences in governance, structure of the health care industry, population density, consumer preferences, and competition within a national framework.

The President's plan recognizes the need for a strong state role in health reform, while establishing federal standards. Under the plan, states would define the number and boundaries of health alliances, the governance of alliances, and many of the functions assigned to the alliances. States also would be responsible for establishing the rules to be followed by health plans, and for certifying that plans are responsive to consumer needs. In addition, states could determine the specific cost control techniques to be used within their borders.

States also would have the ability, under the plan, to implement the health reform plan at varying times. As proposed in the plan a system of incentives, coupled with the flexibility to determine the start date on a state-by-state basis, is supported by the nation's Governors. States that are ready to implement the new system would be allowed to do so, while other states could take more time to plan and learn from the early states. Penalties for states that are unable to meet the transition timeline should be applied carefully and should not be unduly harsh.

The plan also establishes important federal "rules of the game," which the Governors have recognized as necessary underpinnings to state-based reform. These include establishment of a national guaranteed benefits package, insurance reforms aimed at creating fairness in rating practices, changes to ERISA, and administrative simplification provisions.

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* The nation's Governors, through the NGA, have adopted a formal health care policy in support of a state-based managed competition approach within a federal framework. This policy was reaffirmed at the August 1993 annual meeting. While this policy is relatively comprehensive, consensus was not possible on all of the issues addressed in the Clinton plan, and individual Governors may differ considerably on critical issues such as mandates, financing, and enforceable budgets. This statement focuses on one issue of great importance to all Governors: the nature of the state/federal relationship. These comments reflect our understanding of the plan at this time and may change as more details become available.

Governors are concerned about the implementation of enforceable budgets. There is no clear consensus among Governors on the need for or advisability of enforceable budgets for health care spending. If the final legislation incorporates such an approach to cost control, it must ensure that budget baselines and allowable rates of increases are based on reasonable assumptions and are attainable without undermining the quality of the American health care system and without undue federal control over the system. Finally, if enforceable budgets are required, Governors would support states having this responsibility, but with an option for each state to opt out and allow the federal government to do the enforcement.

The exact nature of the President's Medicaid proposal is still uncertain. It is important, however, that the states have assurances of relief from the onerous requirements of the current Medicaid program. Specifically:

- The acute care portion of Medicaid should be incorporated into the new system and must cease to exist as a separate program.
- States must have significant financial flexibility in developing assistance for low-income individuals who might need care beyond the guaranteed national benefits package.
- States must be given considerable flexibility in restructuring the long-term care portions of the current Medicaid program.

The Governors' recognize the special circumstances that low-income people face in securing quality and affordable health care. The plan must be responsive to the needs of all. However, the Medicaid program has evolved over the last twenty years in response to a fragmented health care system. There is no need to keep the vestiges of such a fractured system in comprehensive reform. The Governors strongly believe that fundamental changes to Medicaid must be included in this or any national health proposal.

There are numerous financial implications for states in President Clinton's package. Maintenance-of-effort provisions, program expansion, and elimination of the disproportionate share hospital program could have a negative impact on the fiscal condition of state governments. On the other hand, states could realize sizable savings from the inclusion of various populations in purchasing alliances, from other cost control provisions in the plan, and from predictable rates of increase in health expenditures guaranteed by the plan. States must be financially protected from any mandates or program expansions imposed by the federal government. More time and information will be necessary to determine the precise fiscal impact on states, and that analysis might affect individual Governors' views on the overall plan.

The Governors are committed to working with the President and Congress to find workable solutions in areas of the plan that remain unclear or troubling. We are encouraged by President Clinton's awareness of the pressures faced by states, and of the appropriate leading role for states as the implementers of health reform. We share the President's belief that health reform is critical, and that states should share responsibility for ensuring that reform succeeds.

EXECUTIVE SUMMARY

ColoradoCare is a universal health insurance proposal for Colorado. In 1992, the General Assembly enacted legislation calling for a study of the feasibility of ColoradoCare. This report presents the preliminary results of the feasibility study.

It is our finding that ColoradoCare is an economically feasible proposal that could ensure universal, private health insurance coverage and slow the rate of growth of health care costs in Colorado.

The sections which follow outline the components of ColoradoCare, the problems it is intended to address, the methods used in conducting the feasibility study, and the study's major findings.

What Is ColoradoCare?

ColoradoCare is a universal health insurance proposal designed by and for Coloradans. The plan was developed in 1989 by a private, not-for-profit citizens group known as the Colorado Coalition for Health Care Access.

- ColoradoCare will guarantee uninterrupted health insurance coverage for all Coloradans.
- ColoradoCare will provide all residents with a choice of private health plans, including indemnity plans, preferred provider organizations (PPOs), health maintenance organizations (HMOs), and other plan configurations, such as exclusive provider organizations (EPOs) and point-of-service plans (POSs).[1] The choice of plan will be made by the individual—employers will no longer select plans for their employees.
- ColoradoCare will provide all residents with a comprehensive set of health care benefits, including preventive health care services.
- Under ColoradoCare, every individual, family and business with adequate resources will be expected to pay some of the cost of health care coverage. Health insurance would be financed in much the same way it is now—through a combination of employer, employee, and tax-funded (government) contributions.
- ColoradoCare will create one or more regional health purchasing pools that will be responsible for negotiating the best health insurance deals for all Coloradans. Once the premiums are negotiated, the pool will pay health plans based upon the number of people who enroll in each plan.
- Under ColoradoCare, health plans will not be permitted to exclude anyone from coverage on the basis of that person's health status or income. Once ColoradoCare is

in place, no Coloradan will ever face a waiting period during which certain conditions are not covered.

- Government's role will be limited to qualifying health plans that wish to participate in the ColoradoCare program, performing basic administrative functions, and regulating the market. Every Coloradan will be served by a specific health plan, much as they are now.
- While ColoradoCare will not limit the number of health plans that could participate, the number of plans that remain in the Colorado health insurance market may decline, due to the effects of market competition.
- Employers and individuals will be free to purchase supplemental health insurance packages if they feel that the benefits offered under ColoradoCare are not sufficient.
- ColoradoCare will control costs by changing how people think about and pay for health care coverage—making individuals more responsible. ColoradoCare will reduce costs by forcing health plans to squeeze out inefficiencies. ColoradoCare will control costs by changing the incentives that health care providers currently face to increase the amount of care they provide, rather than hold costs down. ColoradoCare will streamline the health care system and reduce administrative costs by requiring uniform billing systems and electronic data exchange.

ColoradoCare offers a framework for reform. Within this framework, specific alternative ways of implementing the program are possible. The feasibility study looked at a number of these alternatives. For example, the study looked at the costs and implications of:

- Providing any one of three different benefit packages under ColoradoCare;
- Having participating carriers and plans compete either on the basis of benefits offered or on price;
- Financing ColoradoCare with any one of four funding packages;
- Providing a Medicare supplemental package to people currently on Medicare as part of the ColoradoCare program; and,
- Including an expanded long-term institutional and home and community-based care program as part of ColoradoCare.

What Problems Does ColoradoCare Address?

The major problems that ColoradoCare addresses are security and cost.

Security

In 1990, about 500,000 Coloradans had no health insurance coverage. They were not covered by private health insurance or by a government-sponsored insurance program

such as Medicaid or Medicare. Another approximately 430,000 were inadequately insured and thus could be bankrupted by a major illness or injury.[2]

Coloradans want the peace of mind that comes with knowing they have good health insurance coverage—coverage they will not lose if they change jobs, are laid off, divorce, or submit claims for an expensive or prolonged illness. They want their pre-existing conditions covered, they want a choice of physicians, and they want to be assured that critical services are conveniently located and accessible.

ColoradoCare addresses all of these aspects of the health security problem. It provides health insurance coverage for all Coloradans—coverage that stays with the individual when his or her job or income changes. It gives residents a choice of health care plans. And it includes requirements and incentives designed to promote and maintain access to quality care for all.

Cost

Coloradans have almost doubled what they spend on health care in the last seven years.[3] Meanwhile, health insurance premiums for large businesses have risen 79% in the last five years.[4]

The burden of health care costs is shared by businesses, families, and governments. The average payment by large mountain states businesses for each employee's health insurance is $3,262 per year.[5] Between 1985 and 1993, the number of medium to large businesses paying the entire cost of their employees' health insurance fell from 66% to 39%.[6] Meanwhile, the amount that each Colorado family must pay out-of-pocket for health care has risen to $1,223, which accounts for one-third of all health care dollars spent in Colorado.[7]

In 1991, each Coloradan paid $2,037 for local, state, and federal taxes that are spent on health care.[8] The largest state health care program is Medicaid, which provides health care services to some low income people with disabilities and low income families with children. The Colorado Medicaid program cost $404 million in State Fiscal Year 1987; by Fiscal Year 1992 that number had more than doubled to $816 million.[9] Similarly, a large portion of our federal taxes pay for Medicare, the health care program for the elderly. Coloradans paid $394 per person in 1992 toward the Medicare program.[10]

There is nothing implicitly wrong with spending money on health care. However, every dollar that goes toward health care is a dollar not available to families for other goods and services. Every dollar that business spends on insurance premiums is a dollar that is not available for wages, profits, or investments. Every dollar that government spends on health care is a dollar that is not available for other social priorities.

If we do nothing about health care costs, we can expect them to consume an ever greater portion of our productive capacity, and to be an increasing burden on businesses, families, and the government. If we do nothing about health care access, as costs continue to rise, more and more people will find themselves without adequate health insurance. More people will delay receiving care until their condition is life threatening. If we do nothing about health care quality, we will spend ever increasing amounts of money on the assumption that higher technology care is better care, without evaluating the effectiveness of our health care technologies and procedures.

ColoradoCare addresses the cost problem in many ways. ColoradoCare streamlines the financing of health care and reduces administrative costs and waste. It promotes cost-effective care, covers preventive services, and encourages early intervention. ColoradoCare increases individual responsibility, creates consumer cost-consciousness, and promotes private sector competition to control costs. Perhaps most important, by bringing everyone into the health care system, ColoradoCare promotes rational pricing of health care services, which is an essential feature of a well-functioning market.

The ColoradoCare Study

During the 1992 legislative session, the Colorado General Assembly enacted, and Governor Roy Romer signed into law, SB 92-4. This bill, which was sponsored by Sen. Sally Hopper and Rep. Mike Coffman, called for a full-scale feasibility study of ColoradoCare. The bill also authorized the state to seek grant funds to underwrite the costs of the study.

On September 1, 1993, the Office of the Governor received its first funds from The Robert Wood Johnson Foundation of Princeton, New Jersey, to begin the ColoradoCare study. Locally, The Colorado Trust also provided funding for the study. The ColoradoCare project was directed by Alan Weil, J.D., a member of the Governor's Office of Policy and Initiatives staff.

The Contractors

The ColoradoCare project entered into three major contracts. The project contracted with Patricia Butler, J.D., a nationally-known health care consultant based in Boulder, for analysis of a broad range of health care issues. These issues included labor law matters, ERISA, personal responsibility, long-term care, administrative costs, and residency requirements. The project contracted with a work team headed by Jeffrey Zax, Ph.D., a member of the economics faculty at the University of Colorado at Boulder, for an analysis of the long-term economic effects of ColoradoCare. The third contract was with Coopers & Lybrand of San Francisco for actuarial consulting services. The Coopers & Lybrand engagement team was lead by John Bertko, F.S.A., an actuary who has worked with a number of states on health care reform.

Advisory Committees

On January 6, 1993, Governor Romer called together more than 150 volunteer Coloradans to serve on six ColoradoCare committees working on health care reform. These were the access, actuarial, benefits, program finance and economic effects, and quality committees, and the governor's panel of health advisors. During the first six months of 1993, these committees met more than thirty times. Their role was to advise the staff and the project's consultants on the analytical work of the project.

All committee and panel meetings were open to the public. Between January and July, 1993, more than 300 citizens, in addition to the committee members, attended the meetings. Committee chairs generally made time for public comment during each meeting. All meetings were announced in a newsletter that was distributed to more than 3,000 people and organizations.

Highlights Of Feasibility Study Findings

The major finding of this study is that ColoradoCare is feasible. With the sorts of reforms ColoradoCare entails, all Coloradans could have the security of uninterrupted health insurance at a lower average cost than they would face if ColoradoCare were not enacted. Although there are certainly more questions to be answered, the core features of ColoradoCare can be implemented.

It would be feasible to provide all Coloradans with an affordable, comprehensive health benefits package.

The ColoradoCare project analyzed the cost of three sample benefit plans that were designed in consultation with the ColoradoCare Benefit Design Advisory Committee. All three plans would cover a comprehensive set of benefits, including traditional insurance benefits, such as physician, hospital and surgical care, as well as preventive care, mental health care, prescription drugs, and some dental and vision care.

Plan A, the limited plan, requires substantial cost sharing on the part of covered individuals. Except for preventive and primary care, most services would require a 50 percent patient copayment. However, the maximum out-of-pocket expenditure anyone could incur would be $3,000 per year, after which Plan A would pay for 100 percent of covered services. As with all of the plans, under Plan A, low and lower-middle income individuals would have some or most of the copayment requirements waived.

Plan B, the moderate plan, was designed to resemble the typical benefits package that most Coloradans have today. Under Plan B, patients receiving care inside the provider network of their choice would face a deductible of $250 per year and patient copayments

of 10 percent. The patient copayment for preventive care would be capped at $5 per visit, and pharmaceutical copayments would be limited to $7 per prescription.

Plan C is the most comprehensive of the three plans. It has nominal copayment requirements and very broad benefits coverage. Under Plan C, for example, dental and vision care would be treated the same as any other illness or condition and people would pay no more than $5 per prescription.

The feasibility study found that, if ColoradoCare were in operation in 1994, every Coloradan under age 65 could be covered by Plan A at an average cost of $77 per month per person covered. If ColoradoCare were designed to provide everyone with Plan B benefits, the program would cost an average $103 per month per Colorado resident under age 65. Plan C would cost an average of $121 per person per month. These are the costs of providing the three sample benefit plans under the least cost type of plan available in the state—currently, an HMO. Individuals could pay more to get the same benefits from a more expensive plan, or they could buy additional insurance coverage.

It would be feasible to provide every Coloradan currently covered by Medicare with a wrap around package of benefits that would make their coverage at least as good as the ColoradoCare benefits provided to those under age 65.

Medicare is the national health insurance program for the elderly. It provides a basic set of benefits which, in most respects is not as generous as Plan B, the moderate benefit package.

The ColoradoCare project asked Coopers & Lybrand to estimate what it would cost to provide every Coloradan currently covered by Medicare with a wrap around package that would fill in any gaps between Medicare coverage and the benefits offered under Plans A, B, and C. Coopers and Lybrand estimated that it would cost $73 per month per elderly Coloradan to finance a Plan B wrap around package for the elderly. For Plans A and C, the cost would be $43 per month per person, and $100 per month per person, respectively. Once again, these estimates assume that ColoradoCare would pay for the lowest cost wrap-around plan, while individuals could pay an additional amount if they want a more expensive plan.

It would be feasible for ColoradoCare to add an expanded long-term nursing home and home and community-based services program to ColoradoCare.

The feasibility study examined three long-term care benefit plans for possible inclusion in ColoradoCare. The Pepper Commission plan has the least generous benefits, providing a limited nursing home benefit and covering 80% of the cost of home and community-based long-term care services. The American Association of Retired Persons (AARP) plan would cover at least 24 months of nursing home care and would also cover 80% of

the cost of home and community-based long-term care services. The Physicians for a National Health Plan (PNHP) proposal is the most comprehensive of the three plans analyzed. It would cover all needed nursing home and home and community-based long-term care services.

The feasibility study found that the Pepper Commission plan could be provided to Coloradans of all ages at a cost, in 1992 dollars, of approximately $12 per month per Coloradan ($510 million per year). The AARP proposal would cost $19 per month per Coloradan ($790 million per year). The PNHP plan would cost $27 per month per Coloradan ($1.05 billion per year). These proposals would require net spending increases of $100 million, $370 million, and $570 million, respectively.

It would be feasible to finance ColoradoCare by relying primarily on either a payroll tax, a combination of an increased income tax and payroll tax, or an employer mandate to provide health insurance coverage for all employees.

The ColoradoCare project analyzed four financing packages for funding ColoradoCare which were designed in consultation with the Program Finance and Economic Effects Committee. The packages are as follows.

Package #1 would rely on a payroll tax as the primary source of financing. It would tax wages up to the Social Security wage base (currently $59,700) to pay for ColoradoCare. To finance benefit Plan B, the moderate benefit plan described above, the employer and employee under Package #1 would pay a combined 7.8 percent payroll tax. If the costs were split 80% employer/20% employee, the employer would pay a 6.2% payroll tax and the employee would pay 1.6%. Obviously, the Plan A benefit package would require a lower, and Plan C a higher, payroll tax.

Package #2 would also rely on a payroll tax on the Social Security wage base but would exclude the first $3 per hour earned by every worker. This latter provision was included to help lower the effective payroll tax rate on low wage employees and their employers. To finance benefit Plan B, the employer and employee together under Package #2 would have to pay an 11% payroll tax on all amounts earned above $3 per hour, up to the Social Security wage base. If this were split 80/20 between the employer and the employee, the employer would pay an 8.8 percent payroll tax and the employee would pay 2.2 percent.

Package #3 would rely on a combination of an increased state personal income tax and payroll tax. To finance benefit Plan B, the employer and employee together under Package #3 would pay a 5.6% payroll tax on the Social Security wage base. If this were split 80/20 between the employer and the employee, the employer would pay a 4.5% payroll tax and the employee would pay 1.1%. Package #3 would also require an increase in the state personal income tax from 5% to 7.5%.

Package #4 would mandate that employers and employees pay a fixed amount per employee to cover the cost of ColoradoCare. For Plan B this amount would be $146 per employee per month. This amount would raise enough money to cover all Coloradans, including dependents. If split between the employer and employee 80/20, the employer would pay $117 per month per employee and the employee would pay $29. Package #4 includes a premium subsidy for low wage workers. To finance the subsidy would require a 0.4% payroll tax for Plan B.

All four financing packages would derive a portion of their funding from increases in the tobacco products and alcoholic beverages taxes.

ColoradoCare would slow the rate of growth in health care costs.

If ColoradoCare were to begin operations in January 1994, ColoradoCare costs are estimated to grow approximately 3-4% each year until 1999. This is a much lower growth rate than the 9.1% annual increase in insurance premiums that is expected without ColoradoCare. These estimates assume that, through ColoradoCare, Coloradans receive at no cost the lowest cost health plan in their area, and that, if they want to, they may pay the cost differential between that plan and another plan. Although it is unlikely that the ColoradoCare program could be in place before 1996, these estimates give an indication of the savings that ColoradoCare could generate.

ColoradoCare could also be designed to provide every Coloradan with a health plan that offers free choice of provider. Such a plan structure would cost more, and its costs are expected to grow more quickly, but it would make available to every Coloradan a standard level of benefits offered through a less tightly managed health plan.

ColoradoCare relies primarily upon market mechanisms to contain costs. While regulatory approaches to cost containment are a possible alternative, they are not prevalent in ColoradoCare. ColoradoCare has three sorts of mechanisms for reducing the rate of growth in health care costs: cost containment features that are inherent in ColoradoCare, opportunities for cost containment that are created by ColoradoCare, and additional cost containment features that could be enacted with or without ColoradoCare.

ColoradoCare will reduce costs by creating administrative efficiencies, making individual consumers more sensitive to the cost of their health plan, and creating a standard benefit package that allows better cost comparisons. ColoradoCare creates opportunities for cost containment by allowing for a greater emphasis on preventive care, making it more likely that people will choose to enter more efficient health systems, and creating incentives for health plans to be innovative. There are many additional cost containment options that could be adopted. The Colorado Cost Containment Commission is examining some of these.

While a more comprehensive benefit package, such as Plan C, would cost more for the ColoradoCare program, it might actually lead to lower total health care costs. This is because more of the health care system would be brought under the discipline of a well-functioning, competitive system. However, Plan C would also create forces that lead to higher costs because, with more comprehensive health care coverage, some people would use more health care services.

With a less expensive benefit package, such as Plan A, ColoradoCare program costs would be lower. The lower level of coverage of Plan A might lead some Coloradans to use fewer health care services, which could lower total costs. However, with less of the health care system operating with effective competition, total costs could rise faster than they otherwise would.

It is impossible to say with certainty what effect ColoradoCare would have on total health care spending. It is also impossible to know whether a more limited or a more comprehensive benefit plan would have a larger or smaller effect on total spending.

The specific economic effects of ColoradoCare depend on many factors, including the exact plan of benefits which are covered, the financing mechanism selected, and the method of administration. However, in general, Colorado businesses and families would experience long-term savings under ColoradoCare.

As noted above, the ColoradoCare feasibility study looked at a number of different ways of implementing ColoradoCare, including alternative benefit, financing and administrative options. Depending on the alternatives selected, ColoradoCare will affect particular families and businesses differently. However, the following statements about the economic effects of ColoradoCare can be made.

- All financing options require that all but the lowest income families pay something toward their health insurance.
- The four financing options would have different effects on different families. For most of the options, median and low income families with children that currently have health insurance will pay somewhat less for that insurance. Median and high income singles who have health insurance would pay somewhat more for it. For other combinations of family composition and income, the effects depend upon the financing options.
- All financing options require that businesses pay something on behalf of their employees for health insurance. If the moderate benefit Plan B were adopted, and employers were required to pay 80% of the cost of insurance for their employees, businesses as a whole would pay about the same for health insurance as they are paying now. That is, businesses that currently offer insurance would save almost as much in total as businesses not offering insurance would incur in new costs.

- Because most of the financing options are tied to wages, and smaller businesses tend to have the same average wages as larger businesses up to 500 employees, the financing options spread the costs of health insurance fairly evenly across business sizes, although the very largest businesses pay slightly more because they tend to have higher wages.
- If businesses were only required to pay 50% of the cost of the ColoradoCare program, businesses with fewer than ten employees would, on average, continue to pay the same amount as they are paying now. That is, small businesses that currently offer health insurance would experience large cost savings that are about the same in total as the increase in costs for businesses not offering insurance.
- Regardless of the financing option selected, the rate of growth in payments by both families and businesses would be slower under ColoradoCare than it would be if no reform were enacted. This is because of the cost containment features of ColoradoCare.
- In the long run, regardless of how costs are divided between employers and employees, employees can expect to bear between two-thirds and three-fourths of the cost of health insurance. This is because costs that are imposed upon businesses are transferred over time to the businesses' employees. This statement is true both for current employer expenditures for employee health insurance and for the costs of the ColoradoCare program.
- In the long run, an effective universal health insurance program for Colorado that keeps the population healthy and reduces the portion of the economy devoted to health care will benefit the Colorado economy.

Provision will have to be made in the implementation of ColoradoCare to respond to the special availability and access problems of rural populations, ethnic and racial minorities, teens, non-English speaking residents, people with disabilities, and other groups who may have trouble gaining full access to necessary care.

While ColoradoCare will immediately remove the financial barriers to receiving health care that many Coloradans face, it will take additional efforts to overcome the non-financial barriers that exist. Non-financial barriers are particularly a problem for people who live in rural areas of the state, people with low incomes, and people who have limited English-speaking ability.

The proper functioning of ColoradoCare will require a larger proportion of physicians to be generalists than is currently the case, and a larger number of practitioners to locate in currently underserved areas. The financing changes that ColoradoCare will bring should help address both of these problems, but additional efforts may be necessary. Approaches to consider include changing how we train providers, relying to a greater extent on providers other than physicians, providing additional financial incentives to practice in

underserved areas, and determining the appropriate way to integrate public providers with the ColoradoCare system.

Even if services are available under ColoradoCare, people must be able to take advantage of those services. Financing reform, by itself, will not overcome barriers of individual attitudes towards health care, transportation to health care services, and discrimination by providers. ColoradoCare will need to hold health plans accountable for providing services in a manner that is acceptable to the people they serve.

Although low-income Coloradans should find ColoradoCare easier to negotiate than the current fragmented system of free care, subsidized care, and Medicaid, there will be populations that have difficulty even with a streamlined system. ColoradoCare will need to explore ways to reach out to all people so that society has the benefit of their inclusion in the health care system.

ColoradoCare offers many opportunities to ensure that all Coloradans have access to the highest quality health care.

Health care quality has three aspects: providing appropriate care, providing effective care, and providing care in a manner that is appropriate for the patient. Although health care quality in the United States is generally perceived to be of excellent quality, there are areas where quality improvement should occur. These areas include better scientific evaluation of health care procedures, a reduction in variation among styles of practice due to poor information, and a reduction in the delivery of inappropriate or unnecessary care.

ColoradoCare can enhance the quality of health care if it includes the following components:

- In order to participate in ColoradoCare, health plans should have to satisfy specific quality of care requirements.
- Indicators related to health care quality should be monitored.
- Quality control and quality assurance mechanisms should be employed.
- Consumers should be equipped with the information they need to be advocates within the system for quality care.
- Options for malpractice reform should be considered.
- An investment should be made in systems that improve quality.

Conclusion

The design and implementation of any health care reform is a complex undertaking. The full report addresses a variety of issues in greater detail than is possible in this summary. In addition, it notes many issues that will require further analysis.

ColoradoCare presents a vision of how the health care system could function in Colorado. It is never easy to transform a fragmented, inefficient system into a competitive one. Poorly functioning markets sustain waste and duplication. The elimination of that waste, and improvements in efficiency, while beneficial in the long-term, cause dislocation in the short-term.

This report presents a path that Colorado could go down in redesigning its health care system. The speed with which we move will be affected by how quickly we think our systems can adjust to new incentives and pressures for efficiency. This report does not suggest that ColoradoCare is the only option for reform. Rather, it presents Colorado with a number of choices for a vision of Colorado's health care future. If Coloradans desire this future, they should begin the activities necessary to put it into place.

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[1]These terms describe a continuum of managed care options for health plans. An indemnity plan is one that pays providers for each service the provider performs and relies upon very limited managed care requirements such as utilization review or prior authorization for hospital care. In a PPO, the plan contracts in advance with a set of "preferred providers." The providers generally give the PPO a discount off of their normal charges. When an enrollee does not use one of these providers, he or she must pay a larger portion of the health care bill. An EPO is like a PPO, except that the health plan will not pay any charges to providers who are not on the approved list. In an HMO, health care is covered only if it is provided by the HMO's panel of providers. A POS is an HMO that also pays a portion of charges for services that are delivered by providers outside of the HMO.

[2]Dept. of Local Affairs, Colorado State Demographer. Bureau of the Census (1992).Current Population Survey. Who are the Underinsured? (1985) Milbank Quarterly, 63, 476-503. Butler, P., & Yondorf, B.(1990). Analysis of Current Information to Design a Universal Health Plan for Colorado. (Colorado Trust, 1600 Grant, Denver, CO 80203).

[3]Lewin/ICF estimates. Families USA Foundation (October 1990). Emergency! Rising Health Costs in America.

[4]Foster Higgins (1991). Health Care Benefits Survey Report 1.

[5]Ibid.

[6]Mountain States Employers Council (1992) Health & Welfare Benefits Survey, 1990 Chartbook. Heitler, A. & Yondorf, B, (1991-92) Colorado Health Source Book. Mountain States Employer Council (1993) Health & Welfare Benefits Survey.

[7]Families USA. Health Spending: A Growing Threat to the Family Budget.

[8]Ibid.

[9]Expenditures are from the Colorado Dept. of Social Services and do not include refinancing programs such as Teaching Hospital Payments, Disproportionate Share Payments, and the Institutional Provider Assessment (HB 92-1015), or non-Medicaid medical assistance programs.

[10]Families USA. Health Spending: A Growing Threat to the Family Budget.

Chairman WILLIAMS. Thank you.

Our next witness is Mr. Sam Hubbard, who is the Executive Director of the Montana Health Care Authority.

Sam, thank you for agreeing to stay over the weekend so that you could be with us here this morning. We appreciate it.

STATEMENT OF SAM HUBBARD, EXECUTIVE DIRECTOR, MONTANA HEALTH CARE AUTHORITY

Mr. HUBBARD. Mr. Chairman, members of the subcommittee, what I would like to do today is talk briefly about what Montana's approach to health care reform is; and then comment on the role of States in the context of national health care reform initiatives.

It is a great pleasure to be able to address you today, and I certainly don't envy you your task, although I am not sure I envy me my task either.

The Montana Health Care Authority was established in legislation enacted last session, this spring. It received overwhelming bipartisan support, and I think the reason was that it reflects a growing feeling in our State that health care reform is badly and urgently needed.

There were, I believe, four primary factors underlying this feeling. First of all, approximately 20 percent of our population is either uninsured or underinsured.

Secondly, sort of hand in hand with this, we have discovered that surveys indicate that a growing number of those citizens in our State who do have coverage are very concerned about the prospect of losing that coverage for a variety of reasons.

Thirdly, being a very rural State, we are also seeing more and more of our outlying areas losing ready access to primary care services.

And finally, and in some ways most significantly I think, annual increases in our Medicaid budget are playing havoc with the State's finances.

On this last point, it is worth noting that the Medicaid share of our general budget in Montana amounts to almost 20 percent and it is expected at the current rate of growth to reach 30 percent by the end of the decade. Put another way, the projected inflationary increase in the State share of the Medicaid program in Montana during the next biennium will exceed the combined appropriations of our two major universities, not the increase in their appropriations, but their total appropriations. Thus, the belief that we can no longer afford to wait for a reform, that Montana needs to aggressively move to resolve its own problems.

These solutions are to be crafted by the newly established health care authority. The authority consists of a five-member board appointed by the governor with input from legislative leaders. It also consists of four nonvoting members representing State agencies that have the most direct concern with health care delivery and health care reform, and the board will be assisted by five regional health planning boards consisting of at least one member from each county and each region.

The authority is mandated to implement a reform package which incorporates a number of items, but which is designed to address two fundamental problems, universal access and cost containment.

On the access side, the authority is mandated to evaluate the feasibility of a single-payer model versus that of a multi-payer approach and develop possible methods of financing each approach.

The legislation also requires our insurance commissioner to develop two benefit packages, a basic and standard, which will be portable, which must be offered to everyone, regardless of age, gender and preexisting conditions, and which cannot be canceled.

The authority is also charged with the task of developing and annually updating a health care reform allocation plan designed to help those areas of our State that are currently underserved.

As for cost containment, the authority is required to prepare an annual health care expenditure target for the State and to gradually bring the rate of growth of health care spending into line with the overall inflation rate by 1999.

In addition, it will be responsible for preparing a global budget for all health care spending in Montana, for developing a simplified uniform billing system, for increasing the emphasis on wellness and preventive care, for reducing the practice of defensive medicine, for encouraging managed competition, where appropriate, and for establishing a State purchasing pool.

All of these access and cost containment items must be submitted to the legislature in the form of a comprehensive plan for consideration during the 1995 regular session. As you can see, this is an aggressive and ambitious approach to reform. I expect that in the end, the various features of the legislation will be phased in over time and in fact, several will probably be discarded as we gain some experience with how they work.

It is perhaps significant to note that there was a strong consensus which emerged in support of our reform legislation in our State, including providers, insurers and consumers. While I am sure that this consensus will likely fray somewhat over the next several months, for now, there is a surprising level of cooperation and support for Montana moving forward with a health care reform agenda. In the meantime, we are obviously keeping a close eye on developments at the national level, and I must say that our authority is so newly appointed that it has not really had an opportunity to look at the features of the Clinton plan, at least as a group, but I certainly think that they support and welcome national health care reform.

In particular, we would like to see a set of national standards governing benefit package contents and related matters, the establishment of a general process for managing the reform process, and the creation of effective incentives for cost containment.

We hope, however, that the States will be given a major role to play in the future management of their health care systems. But we would urge that maximum flexibility accompany this responsibility so that individual States are allowed to design solutions that are tailored to their special circumstances.

Thank you again for the opportunity to appear before you today. I wish you the best of luck in carrying out your responsibilities.

Chairman WILLIAMS. Thank you.

Our next witness is Marilyn Bell, who is President of the Central Florida Health Care Coalition.

Please proceed.

STATEMENT OF MARILYN H. BELL, PRESIDENT, CENTRAL FLORIDA HEALTH CARE COALITION

Ms. BELL. Thank you.

I am not here representing the State of Florida, but I am here representing the model for the State reform plan in the State of Florida for both quality and group purchasing, and will share some of the details and results of that, besides some comments on our State plan.

The Central Florida Health Care Coalition is a nonprofit organization comprised of employers and providers in the greater Orlando area, representing over 250,000 covered employees and dependents.

We agree there is no more important problem confronting our Nation today than health care and the need for effective and fiscally responsible reform. Our goal is to be a part of the solution holding down cost increases, removing unnecessary barriers to access, and rebuilding the health care system designed to operate at maximum efficiency and obtain the best results of care delivered appropriately.

Since health care is delivered locally, purchased locally, and most of the time paid for locally, we decided five years ago to begin reform locally. I am here today to share our experience, a model for the State of Florida and the results of a private sector initiative focusing on quality of care and employers' group purchasing for value. We appreciate this opportunity to join the national debate, and we respectfully submit these comments concerning long-term strategies for health care reform.

Initially, for quality, we did database studies, and while somewhat affected, our doctors responded with "my patients are sicker," or "I get better outcomes." We could not proceed without a quality measurement to ensure that quality would not be sacrificed for cost savings.

Setting the standard for quality required a system that had validity, reliability, and severity, adjusted for comparing a patient's degree of sickness and established comparative databases. Standards should not look only at averages, but at best demonstrated results.

After careful research, we chose a system that was clinically based, the hospital purchased and used internally. Quality measures were in appropriateness of care, of admission of inpatient and outpatient, and invasive procedure, effectiveness or outcome, did the patient get better, and efficiency, the use of health care resources and cost.

An in-hospital system was visualized which would assess and maintain quality of care as an overall, continuous quality-improvement program. Hospitals and their physicians would be measured against the same standards, but the way in which hospitals internally use that data, how they use that data, and how they adjusted pricing of affected procedures varied from procedure to procedure.

To date, voluntarily, over 85 percent of the licensed beds in the greater Orlando area are voluntarily under the same quality assessment system. The results are quick and widespread. Two large hospitals have actually decreased their internal expense-per-admission by 2 percent in 1992, and again year to date for 1993. Even

more dramatic was their reduction in the use of ancillary services, the number of lab tests, x-rays, therapies, et cetera.

One hospital, a regional neonatal center in a high-risk pregnancy hospital has decreased its C-Section rate to 21 percent in 1993. Two large hospitals, having over 1,000 beds each, have eliminated their Medicare records.

Hospital A had been losing $12 to $13 million per year to Medicare, and with concentrated effort focused on improved patient outcomes, inefficiency of the delivery system. They eliminated this loss in one year. Hospital B, with over 50 percent of its revenue coming from Medicare, had been losing $1,100 to $1,500 per Medicare patient, and in 18 months haves eliminated their losses from multiple efforts of staff and physicians.

Both hospitals estimate an additional cost savings to the community through reduced pricing of $1 to $1.5 million per month, all with improved outcomes of patients. The translation to one employer: 20 teacher jobs in Orange County were saved due to Orange County school system's health care savings.

Value purchasing: In 1990, the Tampa coalition and the Orlando coalition together formed the Employers Purchasing Alliance. Business coalitions can join the alliance and offer member employers access to group purchase of quality products.

The EPA's vision is a purchaser-controlled, managed-care model achieving affordability and value. It is used as volume leverage for quality and price; typical savings of 20 to 40 percent. We have win/win partnerships with employers, providers and patients. And the quality assessment and accountability of providers is a major part. We use same pricing for large and small employers.

Some of the results: In 1991, the City of Longwood, north of Orlando, their 147 employees joined the alliance and an HMO, experiencing a 26 percent rate reduction from its previous managed-care programs. Renewal in 1992 and 1993 were both at a zero percent increase so that both in 1993 and 1994 the city's employees are getting monitored health care at 1991 prices which is already a cost savings with improved quality.

Other members have experienced similar renewal. In 1992, General Mills Restaurants, an international company, joined the national PPO. To date, both employers and the company are saving a combined $1 million per month.

The conclusion of this project: We have demonstrated that purchasers can work in partnership with providers to modify the health care system so that employees can receive appropriate care with good to excellent outcomes efficiently. Quality care controls in the managed-care system is already showing real cost savings. These are results, not just a plan. Group purchasing for quality and price is real value for everyone.

Our private initiative demonstrated successful market reform, used no State or Federal tax dollars, and required no government regulations. All the community is benefiting.

As stated, this quality in group purchasing was a model for State health reform. It is mandatory that States have the flexibility to be able to respond to their specific needs.

In Florida, we have a CHPA, Community Health Purchasing Alliance, which translates to the alliance or HPPC. As stated now,

they are voluntary; there is minimum government regulation; employers are allowed to come together to group purchase. We share group purchasing for quality, patient satisfaction and price. There was no employer mandate; there is allowance for some experimentation so that medicine is not going to become stagnant. There is continual improvement in health care outcomes. The role of the State is to provide the structure, but market reform will occur.

By State law, the CHPA and/or private group purchasing can coexist. There is no caps and no global budget.

I thank you very much for this opportunity.

[The prepared statement of Ms. Bell follows:]

Marilyn H. Bell
President
Central Florida Health Care Coalition

Introduction

The Central Florida Health Care Coalition is a non-profit organization comprised of employers and providers in the greater Orlando area, representing over 250,000 covered employees and dependents. Like most of the more than 150 other coalitions across the country, we agree that there is no more important problem confronting our nation today than health care, and the need for effective and fiscally responsible reform. Our goal is to be a part of the solution - holding down cost increases, removing unnecessary barriers to access, and rebuilding a health care system designed to operate at maximum efficiency and obtain the best results of care delivered appropriately. Since health care is delivered locally, purchased locally and most of the time paid for locally, we decided five years ago to begin reform locally.

I am here today to share our experience and the results of a private sector initiative focusing on quality of care and employers' group purchasing for value. We appreciate this opportunity to join the national debate, and we respectfully submit these comments concerning long-term strategies for health care reform.

History

From 1985-89 the Central Florida Health Care Coalition joined the Florida Gulf Coast Health Coalition in their annual impatient data base study comparisons of hospitals, by DRG by employer of case mix adjusted charges and length of stay using UB-82 billing data as the data source. Hospitals did respond to our data based discussions and made improvements. Physicians responded with comments of "my patients are sicker," or "I get better outcomes."

It became evident that cost containment efforts could not proceed without a quality measurement to ensure that quality was not sacrificed for cost savings. Initial discussions with hospitals and physicians indicated that there was no consensus on the definition or measurement of quality.

Defining Health-Care Quality

As we met with local employers and providers and examined trends in popular and technical literature to begin to define quality health care, several common themes began to develop:

1. Quality = Price. There are two contrary views to this equation: "You get what you pay for" holds that high-quality health care necessarily carries a high price. Therefore, goals of high quality and low cost are mutually exclusive. In reality, high average charges have been highly correlated with limited clinical experience, high complication rates, and high mortality rates (Personal Communication, Allan Brewster, MD, Director of Applied Research and Design, Vice Chairman, MediQual, Westborough, MA, February 1992). "Low cost is the primary goal" sees health care as a commodity. All the purchaser should consider is price. Whereas price is a consideration, it must be evaluated within the context of demonstrated outcomes, adjusted for admission severity.

2. Quality = Capacity. This approach considers the facilities and personnel available to perform quality health care. Measures may be objective statistics such as the nurse:patient ratio or percentage of physicians who are board certified. More subjective measures weigh who has the newest equipment or who practices the most advanced techniques. Whereas these criteria have some validity, they attest only to the capacity to perform quality work, not actual results achieved.

3. Surveys. Several organizations survey physicians or patients on their perception of quality of care received. Health-care surveys tend to skew toward high-cost, technically advanced teaching facilities and provide little practical information for communities not served by teaching facilities. Surveys among local physicians reflect biases based on admitting privileges and various political and financial incentives.

Patient surveys are of great interest to many employers. The patient is, after all, the reason employers are involved in health care. Referring patients to providers who treat them rudely or who do not communicate well can lead to employee relations problems. However, much goodwill can be "purchased" with bedside flowers, lobster dinners, and friendly follow-up letters, all of which do not address quality of care specifically.

Setting a Standard

After examining numerous quality measurements, several minimum standards that must be met by any quality system were identified:

- Validity. The quality model must provide accurate and meaningful measurements of clinical outcomes and resource utilization.
- Reliability. Different observers of the same situation must be able to independently arrive at virtually identical conclusions.
- Severity adjustment. The system must have a reliable method to answer and adjust for the "my patients are sicker" argument.
- Established Comparative Database. We must be able to make meaningful comparisons down to the physician and DRG levels within a facility, across the state, or around the nation. Standards should not look only at averages, but at "best demonstrated results."

After careful consideration, we selected the quality measurement model developed and marketed by MediQual Systems, Inc., a healthcare software and information firm specializing in health-care quality assessment. The MediQual model, as measured by its MedisGroups II system, measures quality along three dimensions: (1) appropriateness (of admission and invasive procedures), (2) effectiveness (did the patient get better?), and (3) efficiency (use of health-care resources).

The Central Florida Health Care Coalition Board of Directors unanimously agreed to support a MedisGroups initiative. An in-hospital system was visualized, which would assess and monitor clinical quality of care as part of an overall continuous quality improvement program. Hospitals and their physicians would be measured against the same standards, but the way in which hospitals internally used that data, interfaced outcome data with financial data and adjusted pricing of affected procedures varied from facility to facility.

As a group of purchasers, we believed that if a hospital had an internal system that gave them the detailed clinically-based physician-level data they needed to make system changes to provide appropriate care with good outcomes efficiently, then we could macro-manage rather than micro-manage health care. All that we requested was periodic summary-level data in order to monitor that continual quality improvement was taking place, changing the performance results. We met individually with the hospitals and their various decision-making groups to discuss our objectives.

Philosophically, all employers and providers agreed that: (1) quality improvement must be a mutual objective, (2) the goal must be community-wide continuous quality improvement against standards, (3) improved efficiencies should lower costs, (4) initial negative results would not be used against providers, and (5) future managed care contracts would reward improvement.

Clearly, the providers supported this initiative. To date, over 85% of the licensed hospital beds in Central Florida are voluntarily under the MedisGroups system. Currently, the Central Florida Coalition is working with Tampa, Sarasota, and Miami Coalitions and their hospitals to be a part of the same process.

The Payoff

The positive results we hoped hospitals would experience were quick and widespread. Two large hospitals have repeatedly slowed the annual increase in their internal expense per admission from previous years and have actually decreased their expense by 2% in 1992 and again year to date 1993. Even more dramatic was the reduction in their use of ancillary services.

One hospital (a regional neonatal center) has also decreased its cesarean section rate from 32%

in 1987 to 21% in 1993. Another small hospital was able to decrease its cesarean section rate from 42% in 1989 to 33% in 1992. A third hospital decreased the length of stay for Medicare patients with pneumonia by one and half days.

Two large hospitals (over 1000 beds each) have eliminated their Medicare losses. Hospital A had been losing $12-13 million per year, and with concentrated effort focused on improved patient outcomes and efficiency of their delivery system they eliminated this loss in one year. Hospital B (over 50% of their revenue is from Medicare) had been losing $1100-1500 per Medicare patient and in 18 months has eliminated their losses through multiple efforts of staff and physicians. Both hospitals estimate an additional cost savings to the community through reduced pricing of $1-1.5 million per month. Translation for employers: 20 teacher jobs in Orange County were saved due to Orange County School System's health care savings.

Toward Value Purchasing

Once the systems were in place for quality assessment and monitoring, the groundwork was laid for value purchasing. In December 1990, the Florida Gulf Coast Health Coalition, which had been developing group purchasing while the Central Florida Health Care Coalition had focused on quality, and the Central Florida Health Care Coalition formed the Employers Purchasing Alliance (EPA).

For a nominal fee, business/health coalitions can join the EPA and offer employer members access to group-purchased quality products. The EPA's vision is a purchaser-controlled managed care model that will achieve both affordability and value in purchasing quality health care. The EPA guidelines are:

- Volume leveraged for quality and price (typical savings of 20%-40%)
- Consumer/purchaser designed and driven
- Build win/win partnerships between employers, providers, and patients
- Includes quality assessment, accountability, and improvement

There are several unique aspects to EPA. It was created based on access to multiple markets rather than guarantees of specific numbers and the same pricing applies to both large and small employers. Next, providers must agree to the EPA's quality measurements and sharing of data. Finally, there is national portability of the EPA concept and membership. Contracted vendors must provide local, statewide, and in most cases national service/products to contracting employers. Two coalitions outside Florida have joined this Alliance and have access to all the products for its members.

Group Purchasing Results

In 1991 the City of Longwood's 147 employees joined EPAs open-ended HMO experiencing a 26% rate reduction from its previous managed care program. Renewal in 1992 and 1993 were both a 0% increase so that in 1993-94 the City's employees are getting their quality monitored health care at 1991 prices which had already been a cost saving. Other EPA members have had similar experience at renewal time. In 1992 General Mills Restaurants, Inc. joined the EPAs national PPO. To date both employees and the company are saving a combined $1 million per month.

Conclusion

Cost containment as a goal has been considered since the 1970s. Serious questions remain as to whether costs have really been contained at all or just shifted to another difficult-to-measure area. Over the short term, managed care as a purely discounted product has probably contributed to escalating cost. We have demonstrated that purchasers can work in partnerships with providers to modify the health-care system so that employees can receive appropriate care with good-to-excellent outcomes efficiently. Quality care controls in a managed care system is already showing real cost savings. Group purchasing for quality and price is a real value for everyone. Our private initiative demonstrated successful market reform and used no state or federal tax dollars and required no government regulations.

Chairman WILLIAMS. Thank you.

Our final witness on this panel is an old friend of this committee and the members of this committee, former Congressman John Erlenborn.

STATEMENT OF JOHN N. ERLENBORN, ESQUIRE, SEYFARTH, SHAW, FAIRWEATHER & GERALDSON

Mr. ERLENBORN. It is a pleasure to see you and be back in this room, where I attended so many hearings over a period of time.

Chairman WILLIAMS. Some of them on ERISA.

Mr. ERLENBORN. Over a period of about 19 years, having joined the committee in my second year of my first term. As I say, it is a pleasure to be here and to address some of the ERISA issues, particularly ERISA preemption and how they might apply under the proposal as we know it that the President has prepared and apparently will send up to Congress in legislative form this week. If he makes his self-imposed deadline, which has been a problem I think over the course of this past year—his deadlines self-imposed seem never to be quite able to be met, and if he hadn't put them in in the first place, it wouldn't have been an issue. I think everybody——

Chairman WILLIAMS. He is an ambitious guy, John.

Mr. ERLENBORN. He is. Everybody I think would recognize that this was such a complex issue that it would take a long time to be prepared to come up with a plan.

In 1974, ERISA was enacted. As the Chairman mentioned, it was a product of this subcommittee, this committee. When it left this committee, it did go for a brief time to the Ways and Means Committee, which kind of ate what this committee did, drafted another title and then went on to the floor of the House.

When ERISA passed the House in 1974, it contained a preemption provision. The Senate version also had a preemption provision, and what came out of the conference to resolve the differences between the two bodies was an even stronger preemption provision than either body had enacted originally.

The ERISA preemption has become controversial; in some ways it has become the subject matter of many lawsuits, but the basic premise I think was and continues to be valid, and that promise is that it is useful, it is valuable to have one set of rules so that you can have uniform benefits, uniform procedures throughout the country, so that employers and employees alike will know that they will not be subject to the vagaries of different jurisdictions, but we will have this uniform system, both for pension plans and for health plans.

Under the Clinton proposal, all that we know of it at the present time is a purloined working draft that became a best seller very quickly, but under the proposal to the extent that we know it from that working draft, there would be some changes in ERISA preemption.

Under the Clinton plan, ERISA's preemption would be modified to apply only to employers and health benefit plans in corporate alliances, would permit taxes and assessments on employers, or health benefit plans in corporate alliances, would permit States to require all-payer hospital rates and to reimburse special commu-

nity providers, and would permit States to mandate a broader benefit package provided that the source of the financing is not payroll-based.

I think it also would allow States to adopt single-payer programs which could be then an exception to the corporate alliance ability to choose the type of health program that they might want. They would be forced in those States to adopt the single-payer approach.

One of the questions that arises that will have to be answered is, what will the effect of making ERISA preemption applicable only to the corporate alliances, what effect will that have on fee-for-service insurance policies that are purchased through regional alliances?

Will those fee-for-service policies then not have ERISA preemption to protect them and the ones who are paying the premiums ultimately from punitive damages under State Fair Claims Practices Acts that you find throughout the country?

We don't know and won't know until we see the financial draft as it comes up here, and then what Congress might do with it.

In general, the Clinton plans requires that all individuals obtain their health coverage through State-based health alliances or, in the alternative, corporate alliances. Corporate alliances would continue to be employee-welfare benefit plans, subject to the new requirements regarding enrollment and benefit disclosure, national standards for claim administration, and so forth.

There will be reserves required, and that again raises a question as to the tax nature for those contributions of those reserves, and that is an issue that will have to be addressed I assume by the Ways and Means and by the Senate Finance Committee. But we now under our tax laws do not allow tax-favored reserves generally for health plans, as we do for pension plans.

Another issue that concerns me is Medigap. Most employers will not even have an option to set up a corporate alliance. Those that do set up corporate alliances will have an incentive, and almost imperative, to not cover their retirees who retire between the ages of 55 and 65, because the only way you can get the subsidy from this proposed plan from those early retirees, is if they are covered under regional alliances rather than corporate alliances.

Employers who no longer manage and have their own plans because they purchased through a regional alliance will then very likely not have Medigap insurance for their retirees after they reach age 65 and become Medicare eligible. I think this is a disincentive for employees built in to provide this Medigap insurance. I know I personally would be concerned because I have Medigap insurance through the State of Illinois, my service in the State legislature. The States no longer will be managing their own plans. They will have to purchase States and local units of government will have to purchase their insurance through the regional alliances.

What then will they do for the retirees who used to have benefits under the State plans through coordination of benefit procedures where Medicare would be primary and the retirees' coverage under the State plan would be secondary?

I see I have already used my time. I have only gotten to a couple of the issues that I wanted to raise, but I think that there are so

many issues, just in this area of the relationship of corporate alliances, regional alliances, Medigap insurance and the protections of ERISA preemption, that maybe you would want to devote a whole day sometime to just examining those issues.

Thank you, Mr. Chairman.

Chairman WILLIAMS. Thank you, John.

We will, as we did with the witnesses, limit each of the members to five minutes of questioning. I have a couple of questions I would like to ask. Being as I am limiting us all to five minutes, I am going to make my questions quick and I would appreciate it if you would do the same with your answers.

Let me ask the three witnesses that are representing their proposed models from the States, should Congress adopt a uniform national benefit package, or should States be allowed to structure that benefit package on their own?

Mr. Weil?

Mr. WEIL. The governors support a uniform benefits package, and I will mention two reasons for that. The first is the most commonly cited one, affordability, so that people can move around the country without concerns. The less frequently noted reason is that the only way for us as a State to judge how well we are doing in cost control is if we can compare our premium costs to the premiums of our neighboring States and neighboring alliances, and if we all have different benefit packages, just like it is hard for a consumer right now to pick among insurance products, because of different benefit structures, it will be hard for us as a State to know if we are doing a good job. We need benchmarks of which we can measure ourselves and that would go a long way towards providing those.

Chairman WILLIAMS. Thank you.

Mr. Hubbard?

Mr. HUBBARD. Mr. Chairman, I think Mr. Weil said it very well. I think our authority would agree that a national benefit package would be extremely helpful for all the reasons that he said, and plus the fact that I guess it enables us to work more effectively with our neighboring States in terms of providing coverage.

Chairman WILLIAMS. Ms. Bell?

Ms. BELL. I think that while a national standard for benefits is acceptable, my concern is that what is proposed in President Clinton's plan is a very generous benefit, including the coverage for eyeglasses, mental health, drug/alcohol and dental, and that I would see that perhaps a basic package that would cover basic benefits and basic coverage may be flexible by State in some of these other areas and phase-in period. If we start out with too generous a package, no one is going to be able to afford it.

Chairman WILLIAMS. I assume that each of you stay in touch with some of our colleagues in other States across the country. Based on that assumption, let me ask a question about the 50 States.

If Congress moves early next year to finalize, pass and send down to the President for his signature a comprehensive reform package, how much time could we reasonably expect it would take the States to be ready to enroll individuals in an alliance in Montana?

Mr. HUBBARD. Mr. Chairman, since we are really just approaching the problem and expect to be fairly well along by early next year, I would suspect that it would be very easy for us to get the structure in place necessary to enroll people by 1995 or shortly thereafter.

I think if we were a lot further into the process of reform, as say Vermont is, from what I know about their approach, it might take us a while longer to make the modifications necessary to do that.

Chairman WILLIAMS. Ms. Bell, how quickly do you think Florida and some of the other States you know about could come into compliance?

Ms. BELL. With our health reform bill as it stands now with our time frames that are set up, our CHPAs are already formed, activated, and will have the basic benefit plan for the State and also initial membership and sign-up targeted is April 1, 1994. So we will already be there.

I expect that to have gotten to this point, it has taken us about 18 months and that is what it will take the other States.

Chairman WILLIAMS. Mr. Weil?

Mr. WEIL. When we consulted with governors' staffs from around the country, we agreed in discussions with the administration that 36 months was an outside timeline, that that is the longest that anyone should need. It basically gives us a year to enact State legislation and then another two years to get it up and running.

Personally, for Colorado, I think we could go well in advance of that. But no one seemed to think that it would take them longer than the 36 months that we discussed.

Chairman WILLIAMS. Let me ask you two questions about the Colorado plan. Will the package of benefits be comparable to that as proposed by the administration, and how long would it take Colorado to go to universal coverage?

Mr. WEIL. We looked at three benefit packages in our study, the middle one of which was fairly comparable to the President's plan, although not identical. For the purposes of our stage of the analysis, we didn't work out all the details of the benefit package, but we looked at one that is fairly comparable, and through completely independent estimates, we actually came up with cost estimates that were also quite comparable.

After enactment, we would need some time to get regulations and the organizational structure in place. I hesitate to give you an exact amount of time, because as we know, self-imposed timelines sometimes come back to haunt you.

But we feel fairly confident that after enactment, within a 1½ years or so, we ought to be able to get everyone in a system that is up and running.

Chairman WILLIAMS. Finally, let me just note that folks from the States that I have talked to individually as well as the three or perhaps four of you, including Senator Still, but others as well, have talked about their efforts to bring their health care costs in line with inflation. The President has proposed doing that as well, and he is being roundly criticized by people saying the numbers aren't real. You can't get health care costs down that low by 1996 or 1997, and yet each of the States we talked to have exactly the same goal.

Now, maybe all the States and the President together are wrong, but it is interesting to note that the criticism of President Clinton would seem to be as if he is the only person in America that believes that that is a doable matter.

Mrs. Roukema?

Mrs. ROUKEMA. Thank you, Mr. Chairman.

Mr. Erlenborn, I want to add another note, that aside from just being around in 1974 and serving on this committee, many of us look to you as the father of ERISA, and I know that the ERISA preemption issue was central, as you have quite accurately outlined, to the law that was passed, and the effective operation of it, up until now.

I would like to hear from the States their responses to your very coherent statement, I thought, as to the benefits, the essential benefits of the preemption question, whereas they seem to be very adamantly opposed to maintaining preemption, if I am correct, at least three out of the four, maybe all four, have proposed repealing preemption.

May I ask the State representatives how you would address, one, the Medigap issue, which I think Mr. Erlenborn addressed very coherently, and two, the problems for businesses engaged in interstate commerce, if you are going to deal with your maximum flexibility on all health care issues. How do we deal with that?

I mean in the real world, how do we deal with it? We are not talking about goals now, we are talking about real live legislation and implementation. Yes, Mr. Weil.

Mr. WEIL. I don't think the governors support a wholesale repeal of the ERISA preemption clause. I think we are looking for limited circumstances in the context of comprehensive health care reform where States would be permitted to design their own systems.

If States are going to be responsible for the infrastructure necessary to administer these plans, we absolutely need to get started, and I think the reform proposals that you are seeing from States express a willingness to the part of States to do the hard work that needs to be done.

So I think we are not looking for no preemption, we are just looking for circumstances under which if we are designing a comprehensive system, we would be permitted to go ahead.

Mrs. ROUKEMA. Mr. Erlenborn, with your experience, do you think that is a feasible possibility?

Mr. ERLENBORN. I think the fears that we have about eliminating or cutting back on ERISA preemption is it will make plans sponsored by employers subject to taxation, and I think that is pretty clear in the President's proposal. But the biggest problem is that an employer who has employees in 20 or 30 or 40 different States, and those States may have, very likely will have, multiple regional alliances, and the employees, each employee will be able to choose through that regional alliance the type of insurance that they want, varying in cost, means that the employer will have to have a relationship with an alliance in every State and in every area, geographic area where there are employees——

Chairman WILLIAMS. Within individual States, possibly?

Mr. ERLENBORN. Exactly. You may have two, three or four different geographic areas with alliances, and that means the em-

ployer will have to be making payments, will have to monitor the coverage, the actual coverage of the employee. Is the employee still alive or dead? The dependents, what is their status? Is it a family plan still or should it be individual coverage? And have to make those determinations and make payments regularly to each of the regional alliances. Very difficult for an employer.

Mrs. ROUKEMA. Thank you. Does anyone else wish to comment?

Yes, Ms. Bell. I am really intrigued with the process that Florida—the experience that Florida has already demonstrated.

Ms. BELL. I agree with Mr. Erlenborn. We have quite a few large employers who are multi-State, and it would be very difficult for them administratively to be able to function in all of those States with separate individual alliances.

One of the reasons that we took the format that we did of a national group employer was so that it would be able to meet the needs of some of these employers.

Mrs. ROUKEMA. I must say to you, I am empathetic more than sympathetic. I really am empathetically in favor of the preemption standard, but I am very, very confused as to where there is a reasonable accommodation here between what the States feel they need and the business community does. But we will continue to work on that.

Please forgive me if I missed this, but did any of the State representatives refer to insurance reform within their States? Because it seems to me that whether we get a comprehensive reform or an incremental health care reform over the next year or so, insurance reform is at the heart of the issue.

Yes, Mr. Hubbard.

Mr. HUBBARD. In Montana, in our legislation, in which again we are just getting started with the implementation of, small group insurance reform is a major part of that legislation. It is largely assigned to the State insurance commissioner, at least as a process to manage, and they are well underway in terms of doing their work, and then at some point in the not too distant future, it will be dovetailed under the authority with the other approaches.

Mrs. ROUKEMA. Well, what are the essential elements, portability?

Mr. HUBBARD. Portability.

Mrs. ROUKEMA. No cancellation for preexisting conditions.

Mr. HUBBARD. Right. Guaranteed issue.

Mrs. ROUKEMA. Community rating?

Mr. HUBBARD. Community rating is a part of it.

Mrs. ROUKEMA. Everybody is nodding their heads. Is everybody in agreement here? And that can be done and must be done, and nobody opposes it?

Senator Still.

Mr. STILL. Thank you.

When we debated the community rating issue at the national level, we decided that we would entertain community rating, but we would leave it up to each State to design if they wanted a modified community rating or a community rating because of different geographical issues. Some States may have a low-income population with a lot uncovered, and if you raise that rate too high, it

causes other problems. So that was something that we chose not to do.

If I could speak for my home State, we have put in place standardization of claim forms. We have a Delaware Health Care Commission. We expect to have a plan on the marketplace by March or April called DelCare. We are implementing Delaware Flex, which is a cafeteria plan which is unfortunately nixed in the current proposal, would not be able to do that, but we are moving forward with those things for our own State employees.

We have already done portability, guaranteed issue, that is in place. The insurance mechanism is now in place and the rules and regulations that have come down from our commissioner to the insurance industry.

So a lot of those things are moving forward irrespective of what happens here, and I think they are moving rapidly in the States.

Mrs. ROUKEMA. Thank you very much. You have been very helpful.

Mr. MARTINEZ. [presiding] Thank you, Mrs. Roukema.

Just to take off on what Mrs. Roukema was just talking about, portability. Within a State's plan, portability exists only within the State, right?

Mr. STILL. No jurisdiction over any other States, so that would be correct, yes, sir.

Mr. MARTINEZ. If we allow the States to do each of their plans, and in a way, I am an advocate of that, I think it will be a lot simpler if we just set the national standards and goals, and then allow the States to move ahead and develop that plan with a certain timeline for implementation of it, something that is reasonable. I don't know how you ever figure that out.

The problem I have with this whole thing—and I am glad you said you were confused, because I get more confused the more I listen to this—we get into questions about ERISA preemption and all the rest of it, and it seems like then it starts to become an almost impossible task. We started out—really the whole problem was created because there are 37 million people uninsured, and we were going to find a way to make sure they were all covered.

So then we started developing a plan that would interfere with plans that are already in place and plans that may be good or bad, and certainly I would be in support of developing a law that first took care of the 37 million uninsured, and then looked at the plans that were in existence and if they were good, leave them alone, and if they were bad, then set that national standard that would cause them to come up to a certain standard.

You mentioned, Mr. Still, the fact that you do not support the seven-man board at NHB, but if we were to allow States to do it, wouldn't there have to be a national board in place that might not have the broad responsibilities that they are outlined to have now, but at least to make sure that the States implemented plans and that they looked at those plans, and the States submitted those plans to make sure they complied with the national standards?

Mr. STILL. Your question is a good question. The best way to respond to that is probably to respond to you what we have done in the Medicare, Medigap market.

In the current system of regulation or rules, you have already established through guidelines at the Federal level, seven, eight different plans that can be now sold into the private sector, yet there is no national health care board that oversees that. The regulation of that product, which is what our senior citizens use to buy their supplemental coverage, the regulation of that is left to the State level, the products are defined, and quite frankly in the marketplace, we have observed a great simplification, more competition and uniformity of benefits, very easy for them to compare and so on.

So that is a classic example of what could occur if the opportunities for flexibility are maintained, the States are regulated at the local level, complaints are handled at that level, and you see tremendous competition in the marketplace. That is the best way for me to respond, that there was no need for a national health care board at that level. And I don't want to go into great detail and dissertation about the powers of this group, but they are pretty extensive.

Mr. MARTINEZ. Well, here again, the question is they may be too extensive now, but I would say that if you are going to allow States to do it, you would need somebody to oversee that, other than the committees.

One of the things that I find in Congress is that the committees have oversight jurisdiction, but they never exercise it and the agencies do as they darn well please, especially sometimes in the States, they do as they pretty much please. So I would see some need for a national board, if not any other than to approve plans, so the States can make sure those plans were in conformance with the national standards and goals and those other things.

But this brings up the point of the preemption of ERISA. Mr. Erlenborn, you were a Ranking Member when I came on the committee, and I can remember that there was always a great deal of comity between you and the Chairman, Mr. Perkins, and that a lot of things were resolved because of that comity, and I would like to see this health care plan come forward with that, but we can't have that if some people are going to be absolutely stubborn about the preemption of ERISA, especially in the area of health care.

You mentioned earlier that the only reason for the clause was to make sure that there were uniform benefits, different kinds of benefits, and you mentioned health care benefits in it. Well, right now as we have it, there is not really uniformity in health care benefits across the country.

Wouldn't it be reasonable to expect that if we did pass a health care plan and it did set a national standard and goal, that in that instance, you have some language in that law that would preempt in that particular area of ERISA?

Mr. ERLENBORN. When I said uniformity of benefits, what you have is the employer provides, either through insurance or through a self-funded plan, the same level of benefits for all employees. That was not to mean uniformity from one employer to the other; that was not the goal, nor was that the fact.

The principal thing was to have everyone know that the right to participate in a plan, the information that you are supposed to get, the way claims are handled and so forth, all of these things were

uniform throughout the country, and I think that the ERISA preemption was successful in that regard.

Mr. MARTINEZ. Well, I can see that. Let me ask you, because I see—you know, five minutes is not very long. We ought to extend that time.

Mr. ERLENBORN. You are the Chairman, you can do it.

Mr. MARTINEZ. As the Chairman, I am going to take a little prerogative here. The thing is that we have social security, is a payroll tax really, the employer pays off, the employer pays a certain percentage and the employee pays a certain percentage. I am wondering why in this health care plan—that is an individual thing aside from any preemption of ERISA, right? So if there were a payroll tax in that vein like the social security tax where the employer would pay half and the employee would pay half, because if you look at just the 37 million uninsured and you were going to say put them on a plan that was comparable with what the Federal employees have and the rates and package were negotiated by the Office of Personnel Management as the Federal plans for the Federal employees are done now, and we have, I think someone told me about an $11 billion cost for the Federal employees, that insurance. I am wondering what—shared out over 37 million, because only a little over 2 million Federal employees—I am wondering if 37 million people expanding that cost shared out, what that rate would be, like the social security.

I would dare to venture that it would be less than that 7.9 percent cap that the President has put in for small employers.

Mr. ERLENBORN. I think employees would be very unhappy if you made that a uniform system, because that would cause employees to pay generally more than they do now. But I may have misunderstood the thrust of your question.

Mr. MARTINEZ. The Federal system I am told is a 70/30 split. I understand that here, if you are trying to achieve something and that is coverage for all of that 37 million that is uninsured without—and then bring in any of the bad plans into conformance with good plans, but you are still trying to make universal coverage, that you are going to have to do it in some way where you make sure the cost is spread out over a broad, broad base in order to keep it down, and then of course the insurance reform is another national component of that, it goes beyond just insurance reform.

I think there has got to be proficient drug reform. Because proficient drugs, you can buy them cheaper abroad than you can here, the same drug, so this is a problem we have.

Mr. ERLENBORN. Let me again raise the issue and it may not—in fact, I will admit that it is not responsive to your question, but I think this question of State Fair Claims Practices Act is a real issue that has to be addressed.

If there is no ERISA preemption protection for a fee-for-service insurance company that deals through a regional alliance, most States, many, many States have punitive damage provisions for these fee-for-service plans, and let me give you an example.

I testified as an expert witness in a case in Florida where the actual damages brought in by the jury were $103,000 and the punitive damages were $12 million. If that were to happen, if the States did not repeal their Fair Claims Practices Act, the cost of insurance

through a fee-for-service plan and a regional alliance would be astronomical, because that ERISA protection would be gone.

So I think that that is a very serious question, whether the States, knowing that they have a limited ability to set rates for insurance, want to have a lot of that money going for damages, which will cut down on the money that can go for health care.

Chairman WILLIAMS. Would anyone from the States care to respond to that? I am running out of time and I don't want to take too much advantage.

Mr. WEIL. If I could, the issue of punitive damages is complex, and we wouldn't want it debated out here today, but I fail to understand why it should be relevant that I as a citizen of Colorado, if a certain practice occurs, that my remedies are different, depending on whether I work for a small business that purchases insurance from what they would be if I worked for a large business that self-insures. I can't imagine that most citizens in the States have any understanding of the different rules that apply to them. They think they have insurance, but in fact they are two completely different systems.

It may be that punitive damages needs some reworking. But I don't think this is the area in which the problem shows up.

Mr. MARTINEZ. Thank you.

Mr. Gunderson?

Mr. GUNDERSON. I will pass.

Mr. MARTINEZ. Okay. Ms. Woolsey. Oh, excuse me, Ms. Woolsey. I am sorry. Mr. Ballenger.

Mr. BALLENGER. I came in before Steve did, anyhow. I am sorry I missed the last two people that made presentations, but I have discussed the issue in other hearings. Mrs. Clinton, when she testified earlier, I told her about a group of small businessmen in western North Carolina, 32 companies intact, that had gotten together and formed N.C. Associated Industries. And she said "Oh, that is great, it is an alliance."

But, Ms. Bell, I missed your presentation, so I don't know if it is the same group or arrangement that you have that I had, but she said, "Well, see, you are going to love this because basically you are going to have the same thing we are talking about." I said, "No, ma'am, right now I think we are running the alliance and when we get through, the alliance is going to run us."

There are some questions that come to mind. I know out of these 32 companies that some businesses are cutting back on the hours. My understanding is the President's plan would require employees working less than 30 hours would have to join regional alliances where you couldn't be covered by a corporate alliance. If business is bad and you don't want to fire any of your workers, and you might take a week off, a week on—I mean, I am doing this as if things are really bad. It seems all of a sudden I am tripping over the mechanism that makes this thing work.

The idea also that is very popular in the country today is the—I guess you would call them temporary workers or contract workers and so forth. When business is slow and it starts to pick up, before you hire permanent new workers, you might bring in these contract workers or temporary workers to work until such time as you find

the business is regularly there, and then you could hire them or hire somebody else.

But it appears to me that both of the two things that I mentioned somehow cause this system that they are getting ready to build to kick us out of what we already have. That is a general, overall question, and I don't know what central Florida health care is, but it might be the same as mine, I don't know.

Ms. BELL. I agree with you with your concerns. What I understand from the President's proposal is that those existing purchasing groups of employers would be out of business. As we have questioned them directly, they have admitted that.

We responded very strongly, because we were the model, and we have been able to show success without the regulation. And I do have concern that there would be a single purchasing group that would be government-controlled in any one area.

The other area of concern is for those part-time workers, temporary workers. What I see employers doing if mandated to provide coverage is they will cut down or eliminate those part-time workers or temporary workers, and they will turn them into full-time workers, because one full-time worker is going to be less expensive than if it was two part-timers or three part-timers.

There are a lot of concerns. In fact, surveys are already being done in how to do that. With some of the large companies, we are talking about an awful lot of people that will be out of the workforce. There are a lot of questions as to what does that mean for those who want to work part-time because they are going to school, those types of situations. And I think we are going to see a tremendous decrease, not only with small employers who are trying very hard to break even or start some profitability, being able to do that, as well as those companies who depend very heavily on part-time workers.

I would like to make one comment from before, that when we look at those 37 million that are uninsured and compare those to the numbers in the government, my first question is, how many in government employ are at the entry-wage level? When you have someone at basic wage level and they are required to pay a percentage of their health care benefit, start some numbers, and it gets to the point that they cannot spend a third of their salary or pay on health care.

Mr. BALLENGER. I have heard it said here amongst members that New York State is one of the ones that wants a single-payer plan. It appears that if there is somebody in this country that does, they are interested in a single-payer plan.

I think, Mr. Erlenborn, this would probably come closer to you. We have a General Electric plan in Hickory, North Carolina, and there are also General Electric plans in the State of New York. If ERISA is preempted or if it is not preempted—I can see just an absolute dog fight because the fringe benefits that will be forced on General Electric in New York State for their employees there, is that automatically—unless they are—I don't know—it appears to me that our little operation in Hickory—it is not a very profitable operation as far as General Electric is concerned. They have thought about closing it several times. It makes distribution trans-

formers, and it is a very competitive business and a very nonprofitable business.

If this thing passes the way it appears it is going to pass, it might make the final decision for General Electric to close the plant. It has 800 people working in North Carolina.

Does such a thing sound like one of the problems that might occur?

Mr. ERLENBORN. That is speculative, but the fact is that General Electric is one of those companies that probably will consider establishing a corporate alliance, although there are many disincentives in the proposed plan for employers to do that. But assuming that General Electric did establish a corporate alliance and in some State they decided to have a single-payer plan, that would be forced upon General Electric in that State.

The level of benefits, whether it is single payer or any other type, HMO, PPO, fee-for-service, the level of benefits in the plan available in that State will become a matter of political determination. Each time the State legislature meets, they will have different pressure groups going for the legislature and saying, "Now you ought to improve that, you ought to cover chiropractic when you didn't before, you ought to cover dental," et cetera, et cetera. So the benefits are going to be driven up in those States, and I think these are problems.

Mr. BALLENGER. If you have a plant like our plant in Hickory, North Carolina that is unionized by the same union that the organization in New York State is, it is not likely that such a thing is going to be forced. I don't know how, if North Carolina were to have regional alliances and so forth and so on, and yet General Electric has a corporate alliance, but it is regulated by the State of New York, it appears to me that it doesn't make any difference what kind of alliance you got in North Carolina, you are going to end up with the same benefits that they have in New York State because the union is going to force it.

Mr. ERLENBORN. Well, I think the unions may try to force it, but on the other hand, I think the tendency is going to be for employers to provide only the level of benefits that is mandated State-by-State, and it is just going to vary, that is all.

In New York you might have the single payer and it might be a very rich program. Employers are going to, to the extent they can—and I think they are going to have a fairly good chance of doing this—say that whatever benefits are mandated, the level of benefits in each of the States, that is what they are going to look for, even though the unions may try to bargain for higher benefits. But whatever the union bargains for, it may not be available in that State, or the employer may have to start some second health plan to provide the additional benefits that are bargained for.

I really have been very surprised that the AFL–CIO, before they even saw the purloin document, were endorsing this plan, not knowing what the ultimate effect would be. I think the effect overall is within time and not too long a time, you are going to see a leveling where everybody is going to have about the same level of benefits, depending on the variations from State to State, and there won't be extra, richer benefits, whether it is through collective bargaining or not.

I think that is the purpose of this plan. It is libertarian. People should not be able to have more health care merely because they have more money or they were successful through a union negotiation in getting more from their employer, but rather, it is an egalitarian plan that ultimately people will all have pretty much the same benefits and will be almost prohibited from getting additional benefits, at least through the system.

Ms. WOOLSEY. [presiding] Okay. Thank you. All of this conversation today just reconfirms in me how much better it would be if we had a single-payer national system. But I really appreciate all of your input. That is because—and I am going to ask you about the financial cost to the States of meeting the responsibilities under the President's health care reform proposal.

Do you think the single-payer system would be more or less expensive to implement by the individual States? I suppose I will ask those representing States.

Mr. STILL. We have not done any serious calculations, so therefore I could only speculate. The administrative costs I think will be less.

I think the real question, I think once you follow that on down though is, what happens to your level of choice? Do you get into rationing? Who fixes the capitation costs and so on?

When we debated this in our committee system, and then again on the floor in July, the final determination was that a majority—and it takes 75 percent of the voting delegates for us to pass a policy statement—the majority said that would be a decision they would prefer left up to each State, number one.

Number two, many States were opposed to—in a rural area and you needed a traditional fee-for-service plan because you don't have the necessary providers in the area, the infrastructure costs to capitalize and build that infrastructure could make it much more costly in a short timeframe.

So we are looking for a framework from the States. We don't have a handle on the exact costs to do all of those things. I think what you would find as a consensus from our group, the National Conference of State Legislatures, is that we prefer that decision left up to each State under a basic framework.

Ms. WOOLSEY. Even though it would cost to administer?

Mr. STILL. We also attach a value to some of those costs. More choice.

Ms. WOOLSEY. Choice. I don't understand choice when the single payer is the system that provides choice of providers in the plans we have talked about. The President's plan does not, unless you can afford it. So I mean I just don't understand, you know, saying choice.

Mr. Weil?

Mr. WEIL. In the context of your study of ColoradoCare, we do look at savings attributable to a single-payer system and we did find that there were administrative savings in the first year if you moved to a single-payer system. We don't have data, because the concept of a single payer is that you set a budget, and so the question is, what budget will you set?

If we are good and tight on that budget, presumably there could be longer-term savings as well, although they do come at certain

costs. I am personally not optimistic that our political process would yield a single-payer budget with slower growth than we have right now. That is only my personal opinion.

Ms. WOOLSEY. Thank you.

Mr. Hubbard?

Mr. HUBBARD. I must say that I am just not capable of answering that question. That is precisely one of the major tasks that our authority is supposed to evaluate, and I just don't have a sense at this point what the outcome might be.

Ms. WOOLSEY. Okay. Good. I have another question, because it is extremely important to me that any health care reform system that we have offer all women a full range of reproductive benefits.

Under the administration's proposal, what role do you see the States playing in deciding reproductive benefits, and how are we going to ensure that they are offered within all the health care plans? What are the States going to do? That is a pretty broad question.

Specifically, including abortion in the full range of benefits, in a basic package, will States be able to impose their own rules under what we have set up now, or how do you see this happening? I mean, that is what—I mean, private plans now include abortion and full reproductive services. So how do you see this playing out?

Mr. STILL. The National Conference of State Legislatures have basically followed what is in existence currently, and sidestepped that issue because of that being from I guess the frying pan into the fire.

But if it is covered currently, I think we would have a very difficult time, especially for medical necessity reasons, of precluding that type of benefit. So there wasn't any real battleground fought over that issue in July when we met. I think you would have a difficult time trying to deal with that hot potato.

Ms. WOOLSEY. Mr. Weil?

Mr. WEIL. I just don't know how the President's plan addresses that and what flexibility it leaves to the States. We have certainly addressed this issue at the State level in other contexts, but I don't know what level of flexibility there is for States in this area.

Ms. WOOLSEY. Well, if States are certifying, then what will be required in the plan?

Mr. WEIL. I guess my understanding is that the benefit package would be defined nationally. And so we would certainly certify features of the plan, if the benefits are defined nationally, then we don't play with that. If there is State flexibility in benefits, we could address that issue.

But again, that would be up to our legislature, and although I am in agreement with you from a substantive perspective, I don't know how it would end up through the political process.

Ms. WOOLSEY. We will go all the way down the row on this one.

Mr. ERLENBORN. If I could address that, if I might, I think from what I have heard about the President's proposal, he leaves that rather fuzzy. It isn't directly referred to as to whether abortion would be made available or not.

It may shock some to know that Congress sometimes does that. I have been in conference committees where we can't really decide whether we are going to take the Senate or the House provision,

and so we adopt some language that would be interpreted either way and both sides claim victory, and then that fuzzy language has to be worked out by the agency that oversees the particular program or settled in the courts, and I think that is the way this is going to be. Each State will have to decide, I guess when they set their level of benefits in the various plans, whether the President or the Congress, if it adopts that language meant this or that, and then ultimately it will have to be resolved in some form.

Ms. BELL. I agree. I think that although some preventive screening tests, there will be very little controversy when you get to the abortion issue. It is going to become such a political hot potato that it is going to hold up reform decisions on the State level and it is going to stay fuzzy and be handled either by the agency in control or through the courts. Otherwise, health care reform is going to be stopped.

Ms. WOOLSEY. But it is all right to go backwards? I mean, women have these services now in their private health care plans.

Ms. BELL. What is going to happen, though, that is going to be one of the things that when you have a total State that is making that decision that it puts it in a political process, that process is not as political as it is determined by an individual employer benefit plan at this time.

Ms. WOOLSEY. Mr. Hubbard?

Mr. HUBBARD. In lieu of their being a national set of standards for what should be contained in benefit packages or a benefit package, our legislation authorizes the insurance commissioner and the authority to determine what should be included in those packages for Montana, and I guess the only thing—and obviously again, as I have said before, we are just starting into that process, but my sense is that some of those services are already mandated by State law, and others that are provided would very likely remain, I think, as part of the basic package.

I also think that the spirit of the legislation strongly encourages consideration of those kinds of matters as a part of the basic packages.

Ms. WOOLSEY. I am not going to keep a grandstand up here, so I really appreciate your input.

I understand that Representative Gunderson has a question or two.

Mr. GUNDERSON. Thank you very much, Madam Chairwoman.

I am trying to reconcile—and I guess, John, this question is for you. Explain to me State flexibility within the context of ERISA preemption and a basic Federal minimum benefit standard. How do you do both?

Mr. ERLENBORN. Well, I think the concept is that there will be a minimum benefit package that would be decided at the Federal level. Without some change in ERISA, the States would not have the ability to mandate, except through the insurance exception to the ERISA preemption provision.

So I think the proposal here is to remove the protection of preemption from anything that is provided through the regional alliances. So the States each then would have a minimum benefit package that is mandated at the Federal level, and they could add to that whatever else they wanted.

In addition, without the protection of the ERISA preemption, any corporate alliance would be subject to taxation in the States. That is one of the things, those four exceptions to ERISA preemption that were in the reconciliation bill, several of them had to do with allowing the States to tax self-funded plans, so that they could provide through that means additional coverage for people who were otherwise uncovered. So that change in ERISA preemption I think is contemplated here also, to allow taxation of self-funded plans.

Mr. GUNDERSON. You don't have a written statement, do you?

Mr. ERLENBORN. I don't, but if leave was given, I would probably prepare one and file it within the time allowed.

[The prepared statement of Mr. Erlenborn follows:]

Testimony of

JOHN N. ERLENBORN

Of Counsel
Seyfarth, Shaw, Fairweather & Geraldson
before the
Labor Standards Subcommittee
of the
U.S. House of Representatives
Education and Labor Committee
Subcommittee on Labor-Management Relations

October 26, 1993

Thank you Mr. Chairman. It is a pleasure to appear before you today to discuss President Clinton's health care reform proposal. It is a special pleasure to be again in this hearing room where for more than eighteen years I participated in hearings and committee sessions as a member of the Education and Labor Committee, this subcommittee and what was then the General Labor Subcommittee. It was the General Labor Subcommittee which, chaired by John Dent of Pennsylvania with myself as Ranking Republican, produced our committee's version of the Employee Retirement Income Security Act of 1974 (ERISA).

Today, Mr. Chairman, I will address some of the issues that I believe are important relative to ERISA and the concept of Corporate Alliances.

By way of introduction, I note that the Clinton proposal has several unanticipated and potentially adverse effects on both business and the health care sector:

1. The Regional Alliances will likely cause a reduction of competition in the market place of ideas for improvement of health care delivery and reduction of costs by drastically reducing the number of consumers of such ideas.

2. Self-funded health care plans are increasingly effective practitioners of cost control through effective use of price competition and plan design. The Clinton proposal will eliminate all small and medium-sized self-funded plans and contains powerful disincentives to the continuation of large ones.

3. The Clinton proposal may virtually eliminate Taft-Hartley plans as providers of health benefits even though such plans have been effective managers of health benefits and have evolved through and been tested by tough negotiations during the collective bargaining process.

4. Increased regulation and audit authority provided to the Secretary of Labor will necessarily give rise to increased costs and, as importantly, the possibility of abuse of authority by the Department of Labor.

5. Multiple Employer Welfare Arrangements -- which have been effective deliverers of health benefits and have enabled many small firms to provide better benefits to their employees -- will be eliminated.

Current ERISA Provisions

Although while conducting hearings and drafting ERISA we generally referred to it as "pension law reform," the law covers "employee welfare benefit plans" as well as "employee pension benefit plans." Under current law, the U.S. Department of Labor administers ERISA reporting, disclosure, fiduciary, COBRA health care continuation coverage standards, and enforcement provisions. ERISA preemption provides that the federal law preempts all state laws "affecting" ERISA-covered welfare benefit plans. The insurance exception to preemption means that the States may regulate insurance used to fund ERISA welfare benefit plans. Thus, an ERISA-covered self-funded health plan is free from state mandates and other regulation, but if insurance is used to fund a plan, state mandates and regulations are enforceable as to such insurance.

President's Health Plan

The Clinton plan requires all individuals to obtain health insurance coverage through either "Regional Alliances" or "Corporate Alliances." Employers would be required to pay at least 80% of the cost of insurance with employees paying the balance.

Regional Alliances will be established by state action and will be either agencies of the state or non-profit organizations. Regional Alliances will contract with state-certified health plans, and individuals will obtain their health coverage through the Regional Alliances.

An ERISA-covered welfare benefit plan is one which is "established or maintained by an employer or by an employee organization, or by both - - -." Under this definition, Regional Alliances and the health plans available through them will not be ERISA-covered plans and thus ERISA preemption will not apply to them.

Corporate Alliances will be established and maintained by large size employers and collectively bargained Taft-Hartley plans. These plans will continue to be covered under ERISA but

will be subject to newly established requirements regarding (1) enrollment and benefit disclosure, (2) national standards for claims administration, (3) reserves and participation in a new national guaranty fund for self-insured plans, and (4) cost containment.

ERISA preemption is changed in significant respects under the Clinton plan. ERISA preemption will (1) permit state taxes and assessments on employers or health plans in Corporate Alliances, (2) permit the states to adopt all-payer rates, (3) permit the states to require all payers (including plans in Corporate Alliances) to reimburse "essential community providers," and (4) permit states to mandate a broader benefit package provided that the source of funding is not payroll based or made applicable only to corporations.

Additionally, states may establish a single-payer system where the state, or its designated agency, makes all payments to health care providers. In that event, a Corporate Alliance may be required to participate in the single-payer system of the state.

Corporate Alliances

"Corporate Alliances" can be formed by (1) employers having 5,000 or more employees, (2) existing, collectively bargained Taft-Hartley plans having 5,000 or more covered employees, and (3) rural electric and telephone cooperatives with 5,000 or more employees. Part-time employees working less than 30 hours per week must be covered under Regional Alliances and cannot be included in Corporate Alliances. Eligible large employers, Taft-Hartley plans and cooperatives can elect to form Corporate Alliances or to purchase health coverage through a Regional Alliance. This is a one-time election made at the time the new law takes effect; and eligible employers, Taft-Hartley plans and cooperatives that purchase coverage from Regional Alliances may not thereafter elect to establish a Corporate Alliance.

Corporate Alliances may provide health benefits to eligible employees and dependents through either self-funded employee benefit plans certified by the Secretary of Labor or through state-certified health plans.

Corporate Alliances, during annual open enrollment periods, must offer a fee-for-service plan and two other plans (e.g., health maintenance organization (HMO), preferred provider organization (PPO), etc.).

Employers contributing to a Regional Alliance would be required to pay no more than 7.9% of payroll for health coverage annually. There is no cap for employers providing coverage through a Corporate Alliance.

If a large employer chooses to join a Regional Alliance, its per-worker premiums would be adjusted for the risk profile of its employees. For the first four years, the employer would pay the greater of (1) the community rated per worker premiums, or (2) its own risk-adjusted worker premiums. For the next four years it would pay a blended rate progressing from 75% risk-adjusted to finally 100% community rated. Subsidies such as the 7.9% cap to which such an employer is entitled would be phased in similarly: 0% during years one through four, 25% in year five, etc. until 100% is reached in year eight and subsequent years.

Claims and Benefit Administration

Under ERISA, Corporate Alliances would be responsible (1) for ensuring that all eligible employees and families obtain coverage for the nationally guaranteed benefit package; (2) for distributing brochures describing costs, characteristics, availability of providers, restrictions on access, and an annual "Quality Performance Report" for each plan option; and (3) for ensuring compliance with national standards relating to uniform claims forms, data reporting, electronic billing, etc.

Health plans offered through both Regional and Corporate Alliances are required to establish standard, federally designed benefit claims procedures. The proposed new health care system relies on the development of alternative dispute resolution procedures to reduce costs and increase the efficiency of the grievance process by setting specific deadlines for resolution of claims and providing for early review of disputes by neutral third parties. If the grievance procedure fails to resolve a complaint, the claimant will have the option of pursuing other legal remedies.

Reserves and Guaranty Funds

Under Regional Alliances, states have the responsibility to certify health plans and establish solvency standards. For Corporate Alliances, the Department of Labor would enforce reserve and national guaranty fund requirements. The new requirements for financial reserves would apply to self-funded plans. Such plans would have to establish a trust fund that is maintained at a level equal to the estimated amount the plan owes to providers at any given time. Reserve

requirements also may be met through letters of credit, bonds or other appropriate security rather than establishing the trust fund.

In addition, a new national guaranty fund for self-funded plans would provide financial protection for health providers in case of a financial failure of a plan. The Department of Labor would oversee the national guaranty fund. It would be funded by assessments on self-funded Corporate Alliances.

The Department of Labor may inspect the books and records of self-funded plans and assume control over plans if they fail to meet the reserve requirement. Health benefit plans are required to notify the Department of Labor if they fail to meet the reserve requirements.

Cost Controls

Both Regional and Corporate Alliances are subject to national cost-containment limits on premium increases. The allowed rate of growth for Corporate Alliance premiums is the same as the national factor for Regional Alliances.

The National Health Board created under the President's proposal will develop a methodology for calculating an annual premium equivalent within a Corporate Alliance. Beginning the third year after implementation of health reform, each Corporate Alliance annually reports its average premium equivalent for the previous three years to the Department of Labor. If the increase in the premium equivalent exceeds the allowed rate of growth during two of any three years, the Department of Labor shall require the employer to purchase health coverage through a Regional Alliance.

ERISA

New ERISA provisions establish fiduciary and enforcement requirements for employers and others sponsoring health benefit plans in Corporate Alliances. These provisions of ERISA will address among other things:

1. Fiduciary requirements for employers, sponsors and plan fiduciaries.

2. Requirements related to information and notification made available to employees.

3. Grievance and benefit dispute procedures for self-funded health benefit plans.

4. Financial reporting requirements for self-funded health benefit plans and for Corporate Alliances.

5. Financial reserve requirements for self-funded health benefit plans.

ERISA preemption will apply only with respect to employers and health benefit plans in Corporate Alliances. However, ERISA preemption will be revised to permit nondiscriminatory taxes and assessments on employers or health benefit plans in Corporate Alliances and allow states to develop all-payer and single-payer systems binding on Corporate Alliance employers and plans.

Issues to be Addressed

Mr. Chairman, now that I have briefly outlined the relevant provisions of the Clinton plan, I will comment on some of its provisions which I believe the Congress and this Committee should especially note.

Alliance Structure

It is no secret that the drafters of the Clinton proposal originally planned to require all employers to provide health coverage through state-established Regional Alliances. An outcry from many plan sponsors moved them to allow the establishment of Corporate Alliances by large employers, Taft-Hartley plans and certain cooperatives. Establishing a threshold of 5,000 employees for Corporate Alliances means that all but a small percentage of the work force will be forced to acquire coverage through Regional Alliances. The virtual elimination of employer and union-multiemployer designed and managed plans would remove an important opportunity to compare private sector plan performance with the public sector Regional Alliances. Much could be gained by plan design, management and cost comparisons between plans responsive to individual and business concerns against the politically responsive state plans.

Employers sponsoring health plans have employed varied program designs and incentives to control health expenditures for their employees. Those forced into Regional Alliances will be divorced from program design and relegated to a role of disseminating information and collecting and remitting premiums. One result will be to greatly reduce competition between private sector health plans and those available through the Regional Alliances. Such competition would be healthy and could help to reduce health care expenditures. The threshold for establishing an employer or Taft-Hartley Corporate Alliance

should be reduced to 1,000 employees, a level at which self-funded health plans have been operating successfully.

Single Employer Corporate Alliance

Under ERISA several types of single-employer health plans have evolved, generally classified as insured, self-funded, and partially self-funded. Additionally, plans now may provide one type of benefit or may offer employees a choice, for example, of fee-for-service, HMO or PPO.

Under the Clinton plan, each Corporate Alliance must offer at least one fee-for-service plan and two other health plans offering the basic guaranteed benefits. All benefits must be provided through a certified self-funded benefit plan or through contracts with state-certified health plans. Corporate Alliances may find that obtaining contracts with the requisite number of plans certified in each of the states where employees reside will add substantially to the administrative costs of a plan.

Self-funded plans generally are fee-for-service reimbursement plans administered by the plan sponsor or by a third party administrator. Cost containment by such plans has been achieved through deductibles, co-payments and benefit structure. An employer choosing to establish a Corporate Alliance self-funded plan would be constrained in plan design by the guaranteed national benefit package. Moreover, the requirement that two other types of health plans be offered by the Corporate Alliance through state certified plans may mean the inclusion of additional state-mandated benefits.

A Corporate Alliance will also be subject to additional reporting requirements, state taxes, maintenance of reserves, mandatory participation in the self-funded guaranty fund, and cost containment requirements. Failure to have at least 4,800 employees, maintain sufficient reserves or restrain the premium equivalent cost of the plan would lead to a termination of the Corporate Alliance and conversion to coverage through Regional Alliances.

The uncertainty, cost of compliance and absence of the premium cap, I believe, would lead most eligible employers to forego the opportunity to establish a Corporate Alliance, a result that may have been intended.

Taft-Hartley Plans

Most large Taft-Hartley health plans are self-administered and provide uniform benefits to all participants. The benefit package and employer contributions

are determined through collective bargaining. These plans provide coverage for eligible employees and retirees.

Under the Clinton plan these large Taft-Hartley plans will have a one-time option to become a Corporate Alliance. The Board of Directors (sic, trustees) of these large plans may elect whether or not to form a Corporate Alliance. Such plans have an equal number of trustees appointed by the union and participating employers. Tie votes are a distinct possibility. In such an event, arbitration and even litigation could result. A speedy resolution would be necessary if the Taft-Hartley plan were to elect the Corporate Alliance in time to establish it while the election is still available.

Many Taft-Hartley plans have contributing small sized employers. Examples are found in the construction trades and teamsters plans. Subsidies in the form of premium caps are available only to employers in Regional Alliances. Small employers in Taft-Hartley plans therefor are unlikely to agree to forming a Corporate Alliance. They may be forced into one, however, if the trustees make that decision.

If a Taft-Hartley plan does not become a Corporate Alliance, the basic purpose of the plan -- health benefits for workers and retirees -- will largely shift to Regional Alliances. It is not clear what role a Taft-Hartley plan would play if it did not form a Corporate Alliance. Supplemental insurance for workers and retirees in Regional Alliances might be provided, but it will be regulated through the National Health Board. A Taft-Hartley plan could also become the conduit for payment of premiums to Regional Alliances.

In any event, it seems inevitable that the collective bargaining agreements through which Taft-Hartley plans are established would have to be opened for renegotiation of the health-related role of such plans.

<u>Comparison of Present System with Proposed</u>

Large employers and Taft-Hartley plans will be assessing the changes and new obligations that the Clinton plan would impose on them as Corporate Alliances.

ERISA health plans are not regulated to the same extent as pension plans. The general reporting, disclosure and fiduciary standards of Title I of ERISA do apply. Compliance requires plans to prepare and disseminate a summary plan description to each participating employee. A plan description and summary plan description as well as annual reports must be filed with the Secretary of Labor.

These current requirements are minor and inexpensive. By contrast, a Corporate Alliance will have to:

1. Submit plans of operation to the Secretary of Labor who determines whether the plan meets all statutory and regulatory requirements.

2. Ensure compliance with national standards with respect to uniform claims forms, data reporting, electronic billing and other requirements.

3. Ensure there are federally designed grievance and benefit dispute procedures in place for self-funded plans.

4. Establish financial reserve requirements for self-funded plans.

5. Meet cost containment requirements.

6. Furnish reports at monthly and annual intervals.

Compliance with these requirements will be enforced by the Department of Labor and will involve new regulations, forms and procedures which may be very expensive. For example, a self-funded plan will be required to determine the premium equivalent of the cost of providing health benefits under the plan, a task which plagued employers preparing to comply with IRC Section 89 before its repeal.

Grievance and Benefit Disputes

ERISA provides that a claim denial set forth specific reasons and provide a reasonable opportunity for review.

The Clinton plan requires that specific federally designed benefit claims dispute procedures be established in both Regional and Corporate Alliances. This system relies on the development of alternative dispute resolution to reduce costs, setting specific deadlines for resolution and early review by neutral third parties. If the claim is not resolved, the claimant may pursue the issue with an alliance ombudsman or pursue other legal remedies.

ERISA provides an exclusive procedure for resolving benefit claims disputes which does not, by design, include compensatory and punitive damages which are often allowed under state law. Absent ERISA protection, insurance companies and health plans may be subject to state laws allowing attorneys' fees, compensatory damages, and punitive damages.

Several issues must be resolved. First, since state-certified health plans will not be covered by ERISA, will insurance companies sponsoring state-certified plans be subject to state insurance "fair claims practices" laws which provide for compensatory and punitive damages? What will the new grievance procedures provide in this regard? Will the changes in ERISA preemption retain protection for ERISA-covered Corporate Alliances and plans? The efforts of the tort plaintiffs' bar in the past to get Congress to allow these extra-contractual damages suggest that the issue will be raised again in the legislative process.

Multiple Employer Arrangements

ERISA recognizes three distinct types of employee benefit plans, single-employer, multiemployer, and multiple employer. In 1983 a bill sponsored by Rep. Philip Burton and me was enacted which established the term multiple employer welfare arrangement or MEWA. The purpose of the bill was to clarify that such plans which were not fully insured were subject to state regulation.

MEWAs, generally, are not ERISA plans but function as purchasing cooperatives to allow unrelated small employers, joining together, to increase their purchasing power in providing health plans to employees. Many are self-funded and administered plans. Often MEWAs are formed by associations such as local chambers of commerce, and industry associations.

The Clinton plan would abolish these MEWAs and force their members into more expensive Regional Alliances. MEWAs should be treated as Corporate Alliances and thus be free to continue what they have done well. As Corporate Alliances, they would be free to provide benefits through self-funded or state-certified plans.

Department of Labor

Large employers will be responsible to ensure that all employees are enrolled in a plan and report the information to the Department of Labor.

Self-funded plans will be required to maintain a trust fund at a level equal to the amount the plan owes to providers at any given time. If reserves fall short, the plan must report to the Department. The Department is authorized to inspect the books and records of self-funded plans and assume control over the plans if they fail to meet reserve requirements.

The Department will establish a Corporate Alliance Insolvency Fund with periodic assessments of no more than 2% of annual premiums with respect to Alliance-eligible individuals.

Each employer is required to provide employees information on an annual, year-end basis. In addition, each employer provides the Alliances information relative to employment, earnings, premium payments, change in status, and identity of each eligible employee.

Investigations and Audits

Corporate Alliances, health plans, employers and fiduciaries will all be subject to the investigative authority of the Secretary. The Secretary of Labor is given authority to conduct investigations and audits as provided in Section 504 of ERISA. As that authority is now exercised, a regional office of the Department of Labor issues an administrative subpoena for the production of voluminous records at the regional Department office. Actual production of the records is not expected. The demand is an application of pressure as a prelude to seeking agreement to enter the business premises to examine the books and records not only of the plan but of the employer or third-party administrator as well.

The Secretary maintains there is no requirement to advise the recipient of an administrative subpoena whether a violation of law is suspected, the scope of the investigation, and whether the material sought is germane to the investigation.

The expansion of the scope of the Department's regulatory authority to all employers combined with the unrestrained use of audit and investigative authority gives rise to legitimate fears of misuse of the Secretary's investigative authority. Health benefit plans have flourished in a regulation-free atmosphere. The Clinton plan's massive increase in regulation of health plans will necessarily increase substantially the cost of delivering health care.

Conclusion

Mr. Chairman, the proposed health care reform plan of the Clinton Administration is a complete restructuring of our health care financing and delivery systems. It is designed, I believe, to require everyone, public and private sector employees, self-employed, retirees and recipients of public assistance into one system with federal minimums and the ability of the states to add benefits and administer the health care system. It harbors the seeds of a state-based single-payer system similar to that existing in Canada.

Employer resistance to mandatory inclusion in Regional Alliances resulted in provisions for Corporate Alliances and self-funded plans. As presently proposed, I do not believe these are of real value and few employers will exercise these options after they balance the cost of compliance and tax liabilities compared to any benefit possible.

I thank you for the opportunity to appear before you today. I hope that I may be of further assistance to the Committee and its members as you proceed with this monumental undertaking.

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Mr. GUNDERSON. I would appreciate that, because I think this whole ERISA question is fairly significant as we try to figure out what we are doing at the Federal level and whether we are or not going to achieve cost savings at the State level.

Based on the discussions to date, do you project that the overall impact cost-wise of a basic minimum Federal benefit plan would increase or decrease costs of health care?

Mr. ERLENBORN. I am certainly no expert. I can only give you my impression. My impression is that we are going to have a lot more in the way of people employed for the management of these plans in establishing these alliances, in manning the alliances and negotiating with various plans, and I think the overall result will be more overhead, and either higher costs for plans or less in the way of health care being delivered.

Mr. GUNDERSON. I miscommunicated.

Mr. ERLENBORN. I am sorry.

Mr. GUNDERSON. What I am trying to get at is, if we have the—I am not talking about the administrative costs. What I am trying to get at is this earlier question of: If we assume that we have the creation of what will be a basic minimum benefit plan for every American.

As we discussed earlier, as this panel discussed earlier, some of those basic minimum plans are going to be a lot better than what some States mandated, but they are going to be a lot less than what other States—I mean, I come from Wisconsin, and I know that there are a lot of things that are provided today tax-free as mandates in insurance in Wisconsin that would no longer be mandated as covered services in the future. At least that is my guess. I mean, a chiropractor would be a good example, mandated in the State of Wisconsin today, my guess is it is not going to be covered in a basic minimum benefit plan.

All right. When you get into that kind of an issue of State mandates versus what the Federal mandated plan will do, do you think we are going to end up overall with a health plan that is more expensive or less expensive than the average today?

Mr. ERLENBORN. If you are looking only at what the State decides to put in the package over and above the national minimum package mandate, that I think will vary from State to State. But it is going to be something that the legislature will be deciding, and this will be the same legislature that enacted the mandates that are existing in each of the States, and mandates to insurance companies are rampant throughout the States.

It is going to be very difficult for State legislators to say, "Well, we decided last year or two or five years ago that we are going to mandate this coverage, and now we have changed our mind and we are not going to." So there would be that tendency to keep all of those State mandates in whatever the State decides will be the package for that State.

Besides that, you have, as I understand it, the minimum that is going to be mandated will be richer than the average health plan that is made available. It is patterned after the very large companies, and it will be a richer level of benefits, which will also be very costly.

So I think both factors will work in the direction of making these plans more costly, more expensive than the average today.

Mr. GUNDERSON. Mr. Hubbard, just to suggest one thing from a rural perspective. One of the concerns some of us have with the Clinton plan is that it doesn't give us the flexibility to define what is "a hospital in a rural setting." And if you indeed want to have the flexibility to redefine the mission, you have to get away from the constraint of the inpatient requirements, classified, et cetera, and I would encourage you from your perspective in Montana to take a good look at that and to perhaps give us some input as to helping us solve that problem.

Thank you, Madam Chairwoman.

Ms. WOOLSEY. Okay. Thank you.

Thank you to this panel. Your breadth and depth of knowledge was really useful for us today. I think we could have carried this on for hours and hours. Thanks for being able to do what you did.

We will include the testimony of all of our witnesses in full for the record, and the record will be held open for two weeks in order to enable you and other interested parties to submit written statements for additional information. So I am sure, Mr. Erlenborn, that would be really useful for all of us.

Mrs. ROUKEMA. Madam Chair, may I just personally thank this panel. I think they have been exceptionally well informed, and probably because they have come from some experience, considerable experience in the field, and I want to express my personal appreciation.

Ms. WOOLSEY. And we all do.

The subcommittee stands adjourned until November 4 when we will hear from administration representative Judy Feder and Ken Thorpe.

Thank you very much.

[Whereupon, at 11:45 a.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows.]

TESTIMONY BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

W. David Helms, Ph.D.
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1350 Connecticut Avenue, N.W., Suite 1100
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June 8, 1993

STATE CAPACITY TO ACHIEVE HEALTH CARE REFORM

Mr. Chairman, thank you for the opportunity to testify today on state capacity to achieve health care reform. My name is David Helms, and I am President and founder of the Alpha Center, a non-profit organization with an 18-year history of providing technical assistance to states and the federal government in health care policy. The Alpha Center began as a Center for Health Planning, providing technical assistance to northeastern states for that program. Among other activities, we now serve as a contractor for the Agency for Health Care Policy and Research (AHCPR) conducting workshops for state and local public officials. We also serve as the national program office for three initiatives of The Robert Wood Johnson Foundation, including its State Initiatives in Health Care Financing Reform program, a program funding the development and implementation of health care reform in 12 states which will soon be expanded to assist more states.

The states represented on the panel today are leaders in state health care reform. They provide important lessons about the types of reform which are politically viable in different regions of the country. They also provide key insights into how states are combining different reform approaches such as "employer mandates," "managed competition" and "global budgets." Even more important, they will provide useful lessons on key implementation issues such as structuring purchasing cooperatives and administering expenditure targets and caps.

While I want to emphasize the important progress states are making, I also want to stress that states need (and I believe would welcome) federal support and guidance. Once the Clinton proposal is formally introduced and is debated along with Congressional alternatives, states are likely to fall into three categories: 1) those states which will wait for actual legislation to be enacted and then do what is required, 2) those states which will try to anticipate what their roles will be based on the reforms being considered nationally and take steps to get a head start on implementation, and 3) those states which believe they have a better alternative and hope to develop it to the point of being grandfathered in. States in both of the latter categories are likely to have the greatest capacity to implement national reform.

Once passed, however, some states will move faster than others to begin the operation of a reformed health care system with their speed far more dependent on the incentives provided in federal legislation than on any current indicators of state readiness or capacity. I was reminded recently about how quickly the former East Germany adopted the West German system. They were given 90 days by law and in 90 days, the new system was in place. Few in this country would recommend a 90-day transition. Nevertheless, there are steps that can and should be taken to expedite the efforts already underway to develop the infrastructure for a new system.

In this testimony, I review briefly where states are today in the reform process and the reasons underlying their efforts. After pointing out the issues for Congress raised by state experimentation with health care reform, I discuss the roles and responsibilities for federal and state government under a national reformed system. Finally, I consider what states will need now in order to move forward with reform. Clearly, states are unable to achieve comprehensive health care reform entirely on their own. Without federal leadership, a few will act to the degree they can. For the rest, the capacity to implement reform is highly variable. The federal government can improve state capacity and expedite the transition to a reformed system through clear guidance, funds to develop needed operational capacity and technical assistance.

1. Why have states been pursuing health care reform?

A. The rate of cost increases, especially for Medicaid, is no longer sustainable

B. The increasing number of uninsured coupled with a recognition of a more fundamental breakdown in the small employer market

C. The recognition that incremental changes which states have tried (e.g., market reforms, subsidy programs) will not achieve their generally accepted goal of assuring universal access

D. Belief that significant savings only can be achieved through more fundamental reform of the financing and delivery systems

E. Uncertainty about the likelihood of action at the federal level in the near term

2. Where are the states in the reform process today?

A. Eight states have passed significant comprehensive health care reform legislation and are at various stages of implementing reform.

Hawaii:	employer mandate; subsidized insurance product
Minnesota:	integrated service networks; subsidized insurance product; targets for limits on growth in health expenditures

Vermont:	targets for global expenditure limits; universal access through either single payer or mandated multi-payer system
Oregon:	coverage of highest priority services under Medicaid; high risk pool; play-or-pay mandate
Washington:	employer and individual mandate; purchasing cooperatives; expenditure limits; subsidized insurance product
Florida:	purchasing cooperatives; Medicaid buy-in; small group market reform
Maryland:	small group market reform; limits on physician fees; administrative reform
Massachusetts:	play-or-pay mandate; subsidized insurance product

B. In addition to the 8 states listed above which are implementing various aspects of their legislated reforms, 4 states are undertaking major demonstrations to build capacity for more comprehensive health care reform.

California:	statewide health insurance purchasing cooperative for small employers
New Jersey:	subsidized insurance product
New York:	electronic claims clearinghouse, global budgeting
Iowa:	health insurance purchasing cooperatives and organized delivery system pilots

C. In addition, 22 states have established commissions or task forces to develop recommendations on health care reform. While these states are certainly far less ready than those above to enact reform, the presence of a commission or task force indicates at least a political discussion has begun in a state. In addition, some of these states (e.g., Colorado, Montana) have very active study bills putting them in a position to implement reform quickly should the state pass reform legislation.

D. Virtually, all of the states listed above have included aspects of health insurance market reform among their activities. The Health Insurance Association of America has recently reported that "26 states have forced insurers to issue policies to anyone who applies, regardless of their health. Thirty-four states have forced insurers to guarantee the renewal of policies. Forty states have placed tighter restrictions on insurance rates."[1]

Thus, most of the states are actively reforming the insurance market and studying more fundamental reforms, with the eight states having passed comprehensive reform legislation being the leaders. See Exhibit 1 to this testimony for more detailed descriptions of the reform efforts being undertaken by these eight states.

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[1]Health Insurance Association of America, as reported in Wall Street Journal, June 2, 1993.

3. What reform strategies are being pursued by leading states?

States are currently at various stages of implementing many of the reform components being discussed at the federal level. These state efforts can be categorized as follows:

A. Major strategies to increase financial access

1. Developing new tax-financed systems
   - Payroll tax on employers and employees
   - Income tax
   - Provider taxes
   - "Sin" taxes

2. Mandates
   - Employer mandates
   - Individual mandates
   - Individual and family health accounts

3. Subsidies for the uninsured
   - Subsidized public insurance program for uninsured
   - Medicaid buy-in

4. Restructuring the insurance market
   - Purchasing cooperatives
   - Standard or minimum benefit packages
   - Small group insurance reforms (i.e. community rating to limit rate differentials, guaranteed issue requirements, limitations on pre-existing condition exclusion periods)

B. Major strategies for controlling costs

1. Expenditure targets and caps
   - Targets for rate of increase
   - Total budget for health care services for state residents

2. All-payer rate setting by sector
   - Hospital & nursing home rate systems
   - Uniform payment systems for ambulatory care and physician services

3. Managed competition
   - Development of purchasing cooperatives
   - Selection by individuals within groups of approved health plans

4. Administrative efficiencies
   - Electronic billing and claims processing
   - Electronic coordination of benefits
   - Electronic remittance

C. Major strategies for improving health delivery systems

1. Development of integrated service networks
   - Promotion of new managed care plans which link hospital and ambulatory services
   - Promotion of networks in underserved urban and rural areas

2. Improvements in access to services for underserved populations
   - Building and expanding primary care
   - Training primary care health professionals to work with underserved communities

4. Should the federal government foster further state experimentation with health care reform?

A. The arguments usually made against promoting extensive state experimentation are:

- States lack the financial resources to cover all of the uninsured without help from the federal government.
- State reforms would require exemption from the federal ERISA statute and waivers under the Medicaid and Medicare programs.
- State reforms, especially those imposing mandates on employers, could adversely affect a state's economy if firms move to other states.
- Large multistate firms would face higher administrative costs with different state systems.
- Allowing states to implement their own reforms runs the risk of dissipating momentum from national health care reform; and once a national plan has passed, it might be difficult to bring those states which moved ahead in a different direction back into the new federal framework.

B. The arguments made in favor of state experimentation include:

- State-specific health care reform strategies are more tailored to local conditions than a national plan.

- It may be easier to build public support for a state-specific reform plan, given its focus on solving local problems.

- State reforms build experience in operationalizing and administering important aspects of reform, such as subsidizing low-income individuals or restructuring the local insurance market.

- Permitting state reforms allows states to serve as laboratories for key reform options heretofore outlined only in policy proposals.

- State experimentation allows states to move now toward access improvements and cost containment while the country awaits major national reform.

5. What are the appropriate roles for the federal government and for states under a national reform plan?

Under a reformed health care system, both levels of government are likely to have key responsibilities appropriate to their roles in a federal system.

A. Important roles for the federal government include:

- *Mandate participation by all parties in the system, including employers and individuals.* Our work with The Robert Wood Johnson Foundation Health Care for the Uninsured Program projects taught that despite significant subsidies of up to 40 percent of the premium for employers, we will be unable to achieve universal access to insurance through voluntary means.[2]

- *Establish a standard uniform financing system.* While a few states have been able to pass legislation specifying how universal access will be financed, this aspect of health reform remains beyond the political means of most states. A federally-specified uniform financing system could reasonably require states to maintain their prior levels of financial contributions. Given their fiscal crises, however, it is unrealistic to expect much of an increase in those levels.

- *Establish a standard uniform benefit package.* A national standard benefit would assure greater equity across states, facilitate coverage by plans covering areas which cross state boundaries, and facilitate coverage by national firms operating in multiple states.

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[2]See W.D. Helms, A.K. Gauthier, and D.M. Campion, "Mending the Flaws in the Small-Group Market," *Health Affairs* (Summer 1992): 7-27.

- *Set clear and consistent national policies for key aspects of operating a reformed health care system.* National rules and guidelines should include:

  1) Parameters for insurance market rules (such as factors which may be used in rating premiums or adjusting for differences in risk)

  2) Minimum firm size eligibility for participation in pooled purchasing

  3) Targets for national and state-specific expenditure limits

  4) Specifications for data to be collected for operating the system, assessing its impact, and making policy improvements

  5) Research on health outcomes, technology assessment, and development of practice guidelines

  6) Quality and access standards

  7) Health personnel distribution goals

  8) Clarification and modification, where necessary, of anti-trust rules

  9) Standards for malpractice reform

B. State roles under national health care reform should build upon states' traditional roles in the health care system, including: 1) developing health personnel training programs; 2) regulating provider quality; 3) controlling the supply of health care resources; and 4) serving as a provider of last resort for those who remain uninsured.

C. Under many of the national health reform plans under consideration, states will need to perform important roles, including the following:

- *Establish and oversee purchasing cooperatives.* States will need to establish the rules and regulations for how these entities operate, including:

  1) the number of purchasing cooperatives and the geographic areas they serve

  2) governance, including composition and procedures

3) data collection and submission

4) methods of adjustment for adverse risk selection

5) the extent to which they may limit the number of qualified plans offered

- *Oversee the development and operation of integrated health networks/plans.* States will need to specify the criteria and standards for qualified networks, monitor adherence to national quality and access standards, assure access to providers in underserved areas, foster the development of networks in selected underserved urban and rural areas, and ensure coordination of certain services with state and local public health systems.

- *Administer eligibility for subsidized insurance.* States will need to determine the need for subsidies for unemployed individuals and low income workers.

- *Conduct a resource allocation process within a system of national expenditure limits.* States will need to play a major role in a number of related areas, including:

  1) Develop a baseline on state expenditures and collect data to understand future expenditures

  2) Establish a process to enforce nationally-set expenditure limits

  3) Implement transitional price controls, if any

  4) Conduct rate-setting or negotiation on unit prices, hospital budgets, and/or capitated premiums

  5) Establish supply controls for specialized services and high technology

  6) Promote and enforce health personnel distribution policies

6. **Under a national reform plan, should states be given the flexibility to implement different reforms? How much flexibility do states want? Why do some want flexibility and others don't?**

States are ready to accept federal direction within a system of shared responsibilities. In general, states believe they should be held accountable for mutually agreed-upon goals regarding access and cost containment, rather than the specific processes used to achieve these goals. This argues for some flexibility and the time and resources states

will need to build their capacity to perform these expanded roles. States are concerned about the extent of their financial obligation to assure access and their accountability for meeting expenditure targets, but many appear ready to accept these responsibilities if given sufficient resources and flexibility to carry it out.

7. What can be done to expedite the transition to a new system?

As noted above, at least 12 states have already taken concrete steps to develop the infrastructure for a reformed health care system. They are likely to be joined by other states which are also actively considering proposals. Despite this significant progress, I believe that about half of the states will be unable or unwilling to take serious steps until a new national system is put in place. However, the federal government can expedite the transition by the following incentives:

A. Provide state reform development grants.

B. Provide technical assistance on the entire range of tasks that states will need to perform.

C. Foster further state experimentation now, prior to the implementation of a new system. Such experimentation will not only build states' capacities but it will serve to provide models offering lessons for national reform or reform in other states. As you no doubt understand well, states will need exemptions from ERISA, Medicaid waivers, flexibility on inclusion of Medicare and other federal programs within the purchasing cooperative (especially for rural areas), and protection from anti-trust laws in order to move forward with such experiments.

Once national reform legislation is passed, states will continue to need funding as well as technical assistance for further development of their infrastructures. However, perhaps most important, they will need clear guidance in the areas specified above. The clearer the guidance and the stronger the federal incentives to implement the system, the faster it can be put in place.

EXHIBIT 1

FOR

TESTIMONY BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

STATE CAPACITY TO ACHIEVE HEALTH CARE REFORM

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FLORIDA

Florida's Health Care Reform Act of 1992 called for voluntary approaches to reach universal access and achieve cost containment goals by December 1994. The act simultaneously established the Agency for Health Care Administration (AHCA) which subsumed various agencies and employees in order to focus the efforts of financing and regulating the health care system into one agency. In addition, the AHCA was charged with submitting a back-up to the legislature plan, such as a play-or-pay employer mandate in case the voluntary efforts failed. A year later, Florida passed the Health Care and Insurance Reform Act of 1993, essentially calling for a reorganization of the health care delivery system.

With the provisions of these two laws, Florida has put into place the structures needed in order to organize the health care system using a **managed competition model. Community Health Purchasing Alliances** (CHPAs) have been designated to coordinate both the purchase and delivery of health care in 11 exclusive regions around the state. These alliances will be nonprofit and will serve a voluntary membership of small businesses (1-50 employees), state employees, and Medicaid and Medicaid Buy-In enrollees. CHPAs covering non-urban populations would be allowed to merge. The roles of the CHPAs would be to (1) regulate alliance membership and the benefits offered by the accountable health plans (AHPs), and (2) disseminate information on AHPs to members and employees of members that can then be used to compare health plans. CHPAs would not be risk-assuming entities.

Florida has also enacted **reform of the small group market**. Typical of this type of reform, Florida requires all insurers to provide **"guaranteed issue"** coverage to small employers, their employees, and any dependents. Medical underwriting and pre-existing condition limitations are prohibited, although benefits provided in riders above and beyond the standard package may be medically underwritten. **Modified community rating** would be required.

Further, Florida is developing a **Medicaid Buy-In Program** (MBI) which is dependent upon a waiver from HHS. The MBI would be open to all persons in the state with incomes below 250% of the federal poverty level who have had no private health insurance in the past year.

Other reforms being undertaken in Florida are the continuation of efforts to reform the rural health care system, the development of practice guidelines, and a study of fraud and abuse.

HAWAII

In 1974 Hawaii passed the **Prepaid Health Care Act (PHCA)** requiring employers to provide health insurance coverage to employees who work more than 19 hours per week. Under the PHCA, employers must pay at least 50% of the premium for these employees; employees can be required to pay up to 50% of the premium, but not more than 1.5% of their monthly wages.

Historically, Hawaii has maintained a **very generous Medicaid benefit** insuring medically and categorically needy individuals, elderly and disabled individuals with incomes up to 100% of poverty, and children under age 6 with family incomes up to 133% of poverty. In addition, expectant mothers and infants are entitled to benefits if their family incomes do not exceed 185% of poverty.

The PHCA and the generous Medicaid benefit, along with Hawaii's historically low health care spending, made it feasible for Hawaii to develop a public financing mechanism, the **State Health Insurance Program (SHIP)**, for the "gap group" -- those not insured through their employer, eligible for Medicaid, or able to purchase private insurance. SHIP is a subsidized health insurance program for the uninsured who are below 300% of poverty. The subsidies are based on income and family size and the benefit package provides strong incentives for outpatient care -- only five hospitals days are covered. SHIP has made several efforts to reduce the barriers to care, including shortening its application forms, developing a broad-based community outreach program, working closely with its public agency partners, and using the media.

Over the past few years, Hawaii has seen its health care costs increase markedly. As a result, in 1990 the state legislature created a Blue Ribbon Panel to propose steps for controlling rising health care costs. In an attempt to address this concern, the state is considering the implementation in January 1994 of **Quest**, a system of managed competition for publicly funded coverage. The proposed program is intended to enhance the quality of care while providing universal access, develop efficient utilization of services while controlling costs, and transform public assistance health care into a more privatized mode while promoting effectiveness and efficiency through managed care.

MARYLAND

Historically, Maryland has favored regulation of its health care system. In the 1976, Maryland established an all-payer hospital rate setting system which still exists today. In addition, Maryland has mandated many health benefits and it continues to operate its certificate of need program.

In April 1993, Maryland passed legislation which mandates further reform of the health care system through a regulatory approach. There are two major goals of the legislation: 1) increasing access to health care through insurance reform, and 2) containing health care costs. The legislation includes the following provisions:

- **New Commission:** The legislation establishes the Maryland Health Care Access and Cost Commission as of July 1, 1993. The commission will gather and publish data on prices and practices, including the fees of individual doctors, and control rates for certain health insurance premiums and medical services.

- **Small Group Health Insurance Reform:** By July 1, 1994 carriers must offer a comprehensive standard benefit plan (to be determined by the Commission) to all employers with 2-50 employees who work a minimum of 30 hours per week. All small groups within a carrier are to be community rated with adjustments for age and geography only. The geographic adjustment is limited to four specified areas of the state, and the allowable difference in community rates will be reduced from 50% to 16% over four years, with the Insurance Commissioner required to report on the feasibility of a pure community rate by October 1, 1998. In addition, pre-existing conditions exclusions are to be phased out by January 1, 1995, but until then they may be applied for only 6 months and must be based on only a 6 month history. The carrier may charge up to 1.5 times as much for deductibles and cost sharing if the person was not previously covered.

- **Practitioners' Fees:** By January 1, 1995, the commission must develop and implement a payment system for all health care practitioners in the state. The reimbursement must include a factor representing resources, a factor representing the relative value of health care services, and a conversion modifier which is the payer's standard, the practitioner's standard, or an arrangement agreed upon by the payer, the physician, and/or the practitioner. The practitioners may set their baseline charges, but if voluntary efforts to control fees are unsuccessful, the Commission can restrict the rates.

Other portions of the legislation address the development and analysis of practice parameters, guaranteed open enrollment in an individual's choice of benefit plan once he or she has been a resident of Maryland for at least 60 days if 60% of Maryland's under-65 population is insured, and the reporting of professional liability claim judgements, settlements, and final dispositions.

MASSACHUSETTS

In April 1988 Massachusetts passed comprehensive legislation, the Health Security Act, which provided for the establishment of a **statewide "play-or-pay" system** to be implemented by January 1992. This provision of the legislation requires that companies with six or more workers either offer health insurance or make a per-employee contribution to a state pool which would finance minimum basic health insurance policies for uninsured workers. Due to changes in the political environment (a new Governor) and in the economic environment (a major recession in the state), the state legislature voted to delay the implementation of the "play-or-pay" employer mandate until 1995.

While the implementation of this major component of the legislation has been delayed, several components of the legislation have been implemented. Disabled children, disabled working adults, and individuals leaving welfare to go to work have been able to obtained health insurance through the Department of Medical Security since 1990, and the number of enrollees continues to increase. Unemployed workers receiving unemployment insurance and individuals not previously insured are also eligible to purchase insurance through the Department of Medical Security. In addition, college students are now required to have health insurance coverage.

MINNESOTA

In April 1992 Minnesota passed the **HealthRight Act of 1992**. The law's primary goals are to provide **expanded access to affordable health care for all Minnesotans** and to **reduce the rate of growth in health care spending.** It lays out an incremental, comprehensive approach to increasing access to care. The MinnesotaCare health plan builds on a former state program for uninsured children by adding their parents and other low income adults. The law also contains significant cost containment provisions and newly devised public processes for setting overall health care spending targets, monitoring providers, reviewing the distribution of new health care technologies, and evaluating methods for collecting health care data. A 25-member Health Care Commission was established which developed a plan for setting financial targets to reduce the rate of growth in health care spending by at least 10% per year for the next five years.

Another major component of the state's reform effort targets the small-employer health insurance market. The 1992 legislation eliminates or restricts certain underwriting practices and authorizes the creation of a statewide reinsurance pool and a health insurance buying cooperative for small firms.

In January 1993, the Health Care Commission submitted additional legislation, which includes its cost containment plan. In May 1993 the MinnesotaCare Act was passed. This legislation authorizes the formation of **integrated service networks (ISN)** beginning in July 1994 and mandates an **all-payer system for services not covered by an ISN** to be phased-in over a two year period beginning July 1, 1994. In addition, this legislation establishes the **annual limits on growth in health care expenditures** as follows:

1994: CPI + 6.5%
1995: CPI + 5.3%
1996: CPI + 4.3%
1997: CPI + 3.4%
1998: CPI + 2.6%

Health insurance companies, HMOs, and other health plans will be required to keep their expenditures and revenues within these limits for 1994 and 1995. Providers will be required to keep their revenues or fees within these limits for 1994 and 1995. ISNs will be required to hold the annual growth in their total costs to the limits, and non-ISN services will be controlled through the regulated all-payer system.

Other aspects of the legislation deal with the establishment of an information clearinghouse to compile and disseminate information on health care costs and quality, the development of methods of allocating and assessing the costs of medical education and research, the establishment of specific public health goals, technology assessment, and the role of the Health Care Commission.

OREGON

The Oregon Health Plan, as legislated in 1989, encompasses Medicaid expansion, incentives and mandates for employment-based insurance coverage, insurance market reform, and health coverage for persons currently considered uninsurable. Oregon plans to rely heavily on managed care to deliver cost-effective health care services.

A **single basic benefits package** will be made available to the expanded pool of Medicaid beneficiaries as well as those covered through their employers. A more well-known aspect of the Oregon Health Plan, the **prioritized list of health care services** was developed with the input of consumers, providers, and the judgement of the members of the original Health Services Commission. An ongoing Health Services Commission will be charged with modifying and updating the prioritized list while the legislature will allot the Medicaid budget which will used to determine how many of the services on the list can be included in the benefits package. On March 19, 1993, HHS approved the benefits package as it now stands. Any changes in the prioritization or the cut-off point would require further HHS approval. Questions regarding the impact of the Americans with Disabilities Act (ADA) on the Oregon's prioritized list (as well as any other state's benefits package) are still not reconciled.

In order to increase the number of those covered by **employment-based health insurance**, Oregon has legislated insurance market reforms, focused on the use of the **state's high-risk pool**, and has slated a **play-or-pay mandate to go into effect in 1995** if the voluntary enrollment goal of 150,000 has not been met by then.

Oregon has also: (1) charged a Health Resources Commission with looking into ways to increase the efficiency of the use of technologies, services, and facilities, and (2) begun to investigate increasing health insurance coverage by coordinating worker's compensation insurance with health insurance (e.g., 24-hour coverage).

VERMONT

Vermont's newly established Health Care Authority is currently charged with developing two proposals -- a Canadian-style single payer system and a multi-payer plan requiring all insurers to offer a uniform benefit package. The Health Care Authority consolidates the staff and resources of the state's health planning agency, its hospital budget and health data organization, and its certificate of need (CON) program into a single, coordinated agency responsible for overseeing reforms and shaping a more integrated health care system.

Each of the two proposals must provide **universal access to health care**, utilize **global budgets** for all health care expenditures, and have an overall statewide plan for the allocation of health care resources. The Health Care Authority's analyses of the two proposals is scheduled to be presented to the Vermont legislature in November 1993, where one of the proposals is expected to be approved. Under either proposal, **global budgets** will be combined with binding hospital budget reviews, the CON program, and compliance with the state's plan for the distribution of health care resources. **Non-binding expenditure targets must be developed by July 1993, and a unified health care budget must be in place by July 1994.**

In addition, Vermont will develop a **unified health care database** incorporating data on health care expenditures and the utilization of services. This database will assist the Authority in determining the capacity and distribution of resources, identifying unmet needs, comparing costs, and providing information to consumers and purchasers.

To improve health insurance market performance, Vermont is developing a health insurance purchasing pool for those covered by state government, state colleges, the University of Vermont, municipalities, school districts, and portions of the Medicaid case load. Vermont is also considering a uniform claims form, uniform utilization review procedures, and recommendations to include long-term care services in whichever universal access plan is chosen.

WASHINGTON

The Washington Health Care Commission worked for approximately two years to develop recommendations for health care reform. Based in large part on its recommendations, the state recently enacted the Washington Health Services Act of 1993, becoming one of the first states to pass comprehensive reform.

The following are key elements in the legislative package.

- **Washington Health Services Commission**: The Commission established by the legislation will consist of five full-time members charged with creating a **uniform benefits package**. They will establish a maximum **community-rated premium** annually, subject to the statutory requirement to "ratchet down" the premium until the annual increase is no more than the five-year average rate of personal income growth. The Commission will determine the need for risk-adjustment mechanisms for certified health plans; monitor growth in health services costs; monitor the application of technology; evaluate and approve major capital expenditures; and establish reporting requirements for certified health plans. In addition, the Commission will establish the financial participation levels of enrollees (based on income) and propose voluntary guidelines for certified health plans regarding risk- and utilization management, the use of technology, and methods of payment.

- **Employer Mandate**: The employer mandate requires that employers pay at least 50 percent of the cost of the uniform benefit package for each employee and his or her dependents. Pro-rated contributions for part-time workers and their dependents are also required. The legislation also provides for short-term subsidies for small businesses and would permit employers to purchase insurance through the Washington Basic Health Plan. The mandate will be phased in by employer size:

  - 500 or more employees by July 1995 (dependents by July 1996)
  - 100-499 employees by July 1996 (dependents by July 1997)
  - Fewer than 100 employees by July 1997 (dependents by July 1999)

  We note that while the legislation mandates employers to provide insurance, implementation of the mandate would require that Washington obtain an exemption from the federal ERISA legislation.

- **Individual Mandate**: The individual mandate requires every individual to have health insurance coverage by 1999.

- **Health Insurance Purchasing Cooperatives (HIPC)**: The legislation designates four regions in the state and mandates that one HIPC be established for each region. Based on the state's population, the legislation estimates that each HIPC should have at least 150,000 members. The Washington Department of Health will operate a central information clearinghouse to assist the HIPCs. The responsibilities of this clearinghouse include the establishment of a risk profile information system to permit the equitable distribution of risk among certified health plans.

  The HIPCs will be member-governed and owned nonprofit cooperatives that are certified by the Insurance Commissioner. HIPCs will be required to admit all individuals, employers, and groups and to make available to members every health care program offered by every certified health plan operating within the cooperative's region. They will manage centralized enrollment and premium collection and distribution among certified health plans.

- **Certified Health Plans (CHPs)**: CHPs are required to offer all elements of the uniform benefit package by July 1, 1995. They must offer prepaid per capita community rated premiums that do not exceed the maximum established by the commission. Geographic boundaries will be established within which they will obligate themselves to deliver the services required to any state resident within its service area. Supplemental services may be offered if they are community rated.

The legislation also provides for increasing the enrollment in the Washington Basic Health Plan and Medicaid. Washington plans to finance the expansion of state programs through various taxes, including "sin" taxes and taxes on nonprofit hospitals. The legislation designates the Washington Health Care Authority (an executive agency which now administers state employees' insurance) as the Consolidated State Purchasing Agent (CPSA) for state government. On or after July 1, 1995, the HCA will be merged into a single community-rated pool along with the Basic Health Plan, school districts, and state employees. Other provisions of the legislation include limited antitrust immunity through the state action doctrine for the formation of networks, the creation of a state-wide data system, short-term insurance reform, and public health financing and governance.

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